CLINICAL KINESIOLOGY

VOL III: TMJ, HYOID AND OTHER CERVICAL MUSCLES AND CRANIAL MANIPULATION

Dr. Alan Gary Beardall

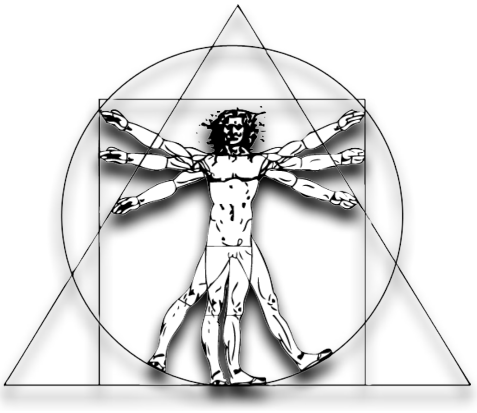
Dr. Christopher Alan Beardall

EDITED BY

BOB SHANE

ARTWORK BY

JOEL ITO
MARLON J. FURTADO
MATHEW J. BEARDALL



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All enquiries should be addressed to:

Clinical Kinesiology
1551 Pacific Hwy
Woodburn, Oregon 97071
PH: (503) 982-6925 or Fax: (503) 213-6020
clinicalkinesiology@hotmail.com
www.clinicalkinesiology.com

DEDICATION

by the late Dr. Alan Beardall

**To my wife without whose
encouragement and support this
book would not be possible,**

AND

**To my patients in the hope that the
knowledge gained by their suffering
and pain may be of benefit to all
Mankind.**

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PREFACE

I first became interested in Applied Kinesiology while I was a student at Los Angeles College of Chiropractic. As I became more involved with the treatment of track and field injuries, I found that Dr. Goodheart's contributions to the treatment of musculoskeletal injuries were truly valuable. This gave me the impetus to become more proficient in the basic Applied Kinesiology procedures. By the Summer of 1975 I was qualified for diplomate status. Treatment successes (and in some instances, failures) using Dr. Goodheart's information on the original forty-five muscles placed an increasing demand on me for information on muscle groups beyond that already available. By 1975 it was apparent that Dr. Goodheart was involved in many other research projects, and if further information on muscle therapeutics was to be forthcoming, it would be through personal research efforts. With these considerations in mind I undertook the task of researching and presenting this information for the other members of the profession. The process was slow and difficult at first, but by following some of the concepts Dr. Goodheart originally presented and by constantly testing and monitoring results, a measure of understanding was achieved.

The information that follows represents four years of clinical research into muscle testing and treatment using Applied Kinesiology procedures. It is provided to supplement existing information regarding diagnosis and treatment of muscular hypokinesia using Applied Kinesiology. Further information about Applied Kinesiology can be obtained from the International College of Applied Kinesiology, 542 Michigan Building, Detroit, Michigan 48226.

INTRODUCTION

In order to preserve the trademark and originality of Dr. George Goodheart's work in Applied Kinesiology, this series is titled *Clinical Kinesiology.* Clinical Kinesiology refers to observations and findings which have proven to be consistent and practical over a period of time within an Applied Kinesiological clinical practice.

The work that follows is an outgrowth of such research by Alan G. Beardall, D.C , in his personal practice at Lake Oswego, Oregon, and is not intended to reflect a consensus of information or opinion in the field of Applied Kinesiology. It is hoped that sharing this information will help improve musculoskeletal diagnosis and treatment and will give us a better understanding of the complexity of this marvelous vehicle we call the body.

This volume is the third in a series of seven workbooks each of which will contain information about muscles pertaining to a given region of the body. Thus, *Muscles of the T.M.J and Hyoid* concerns those muscles linking the mandible and hyoid as a functional unit. All muscle tests are clearly demonstrated. It is hoped that we will be able to provide a comprehensive work on all the significant muscles of the body in this manner.

Each workbook will contain muscle worksheets which identify factors contributing to muscular hypokinesia. The worksheets are very similar to those used in our office and provide what we feel is the basic information necessary to diagnose and effectively treat a local muscle aberration. The information is laid out so that items in regular print are most pertinent to the anterior surface of the body (while patient is supine) and items in italics pertain to the posterior surface of the body (while patient is prone). It is stressed that this is a workbook only and is designed for clinical application. A further explanation of its contents and of the procedures for evaluation and treatment of muscle and cranial dysfunction, visceral organ reflexes, lymphatics, gait and cloacal imbalances, etc. is available in the *Clinical Kinesiology Instruction Manual* [1]. Further information about Applied Kinesiological procedures may be obtained in the works of Goodheart,[2] Walther [3] and Stoner.[4]

[1] Beardall, Alan G., D.C. Clinical Kinesiology. Instruction Manual, 1551 N Pacific Hwy, Woodburn, OR 97071

[2] Goodheart, George D.C. Applied Kinesiology, Workshop Procedural Manual, Annual Research Supplements, 542 Michigan Building, Detroit, Michigan 48226.

[3] Walther, David, D.C Applied Kinesiology, The Advanced Approach to Chiropractic, Systems D.C., 275 W. Abriendo, Pueblo, Colorado 81004.

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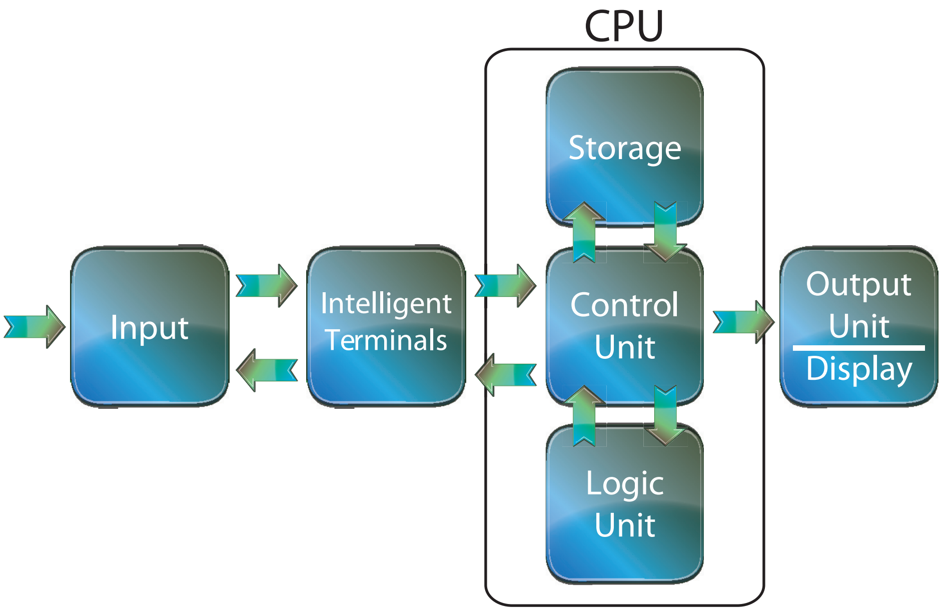
CHAPTER I:

THE LIVING COMPUTER

I. THE ELECTRONIC COMPUTER

Our clinical observations at this time lead us to conclude that the body is a biological computer which has an extensive nervous system with processing capabilities similar to that of a computer. To increase our understanding of this biological computer, let us first consider basic computer functions and terminology.

A computer can be defined as an "electronic machine for the purpose of high speed performance of logical operations for the processing of large masses of coded[1] information."[2] In simpler terms it is "a device that accepts information, processes it and produces meaningful results."[3] The computer has three basic functions: input, central processing and output.



The input unit is the sensory system of the computer: it gathers raw data and breaks it down into small parts that can be handled simultaneously one item at a time.

The computer contains many intelligent terminals which detect and correct certain operator errors as well as capture and enter raw data. All data must be accurate and properly timed. Aberrant information results in the "garbage in/garbage out" phenomenon.

Information is next sent to the central processing unit (CPU) where all data is coordinated and controlled. Here the raw data is transformed into common codes so that the computer can determine whether it recognizes the information received.

Central processing is divided into three parts: the arithmetic or logic unit, the storage unit and the control unit. The arithmetic unit performs logical operations such as the comparison of two items of data. The storage unit stores the data while it is being processed. Whatever is passed on to storage is received in abstract symbolic terms and stored as general facts about the state of the environment. The capability of a computer to "remember" is one of its most essential aspects as it cannot function unless it can store instructions, facts and figures for retrieval when needed. Stored data remains there until it is called upon by the control unit. The control unit is vital for it's ability to direct overall functioning of other units and the data flow between them. This unit contains the programmed instructions which must be written in the language of the computer. The central processing unit has a hierarchical arrangement with each level having a number of relatively independent processing elements each pursuing its own job and each trading information with levels above, below or laterally and with each other. Different aspects of problems are handled in different portions of functional subsystems and are represented potentially at all major levels of the physical system.

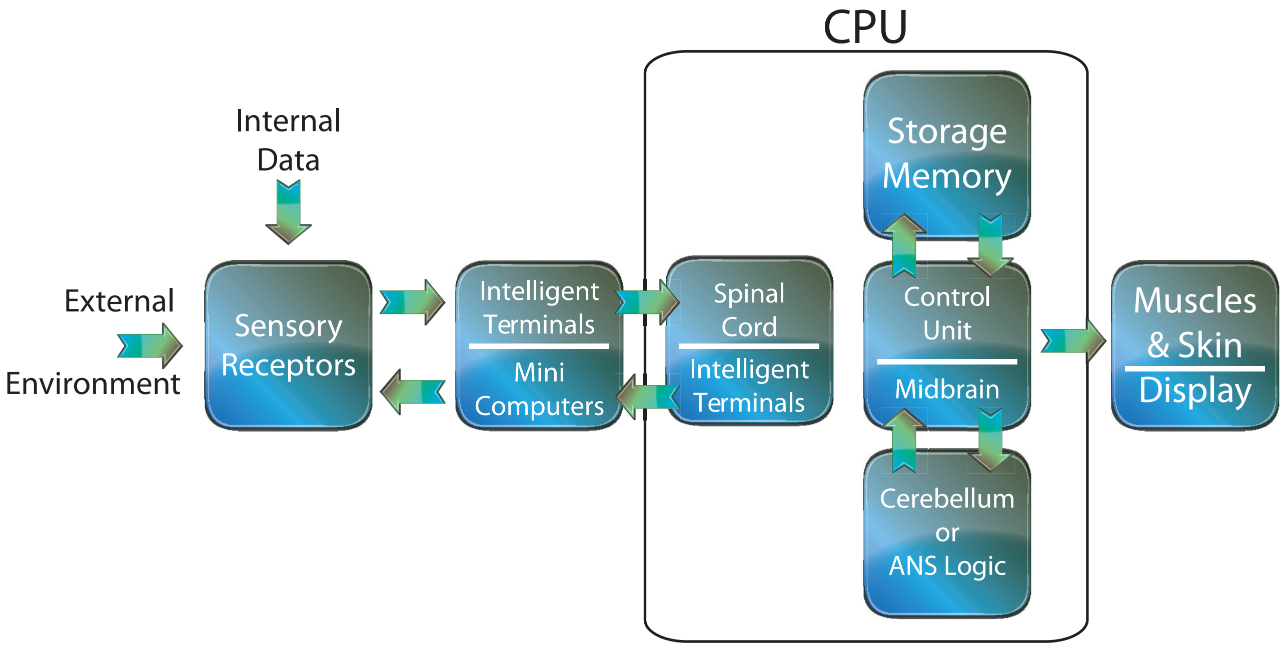
The output unit reports on information from storage and transmits the strategies to the display unit. This unit then reflects the desired actions and computations of the CPU.

In summary, a computer is involved in manipulation of large amounts of sensory data which is processed for input error, monitored, coordinated, controlled, compared, integrated, evaluated and reacted upon to produce adequate solutions to complex problems.

II. The Biological Computer

With our understanding of the electronic computer, let us now compare these qualities with the biological computer. The human body is a complex combination of different types of organs and tissues. These tissues are involved in a series of interreactions both with external and internal stimuli (raw data). This raw data is interfaced with and if necessary reacted upon. These reactions must reflect the "desired action" or will of the primary tissue involved with the problem. The reaction may result in modified behavior or motion, thus the statement "body language never lies."

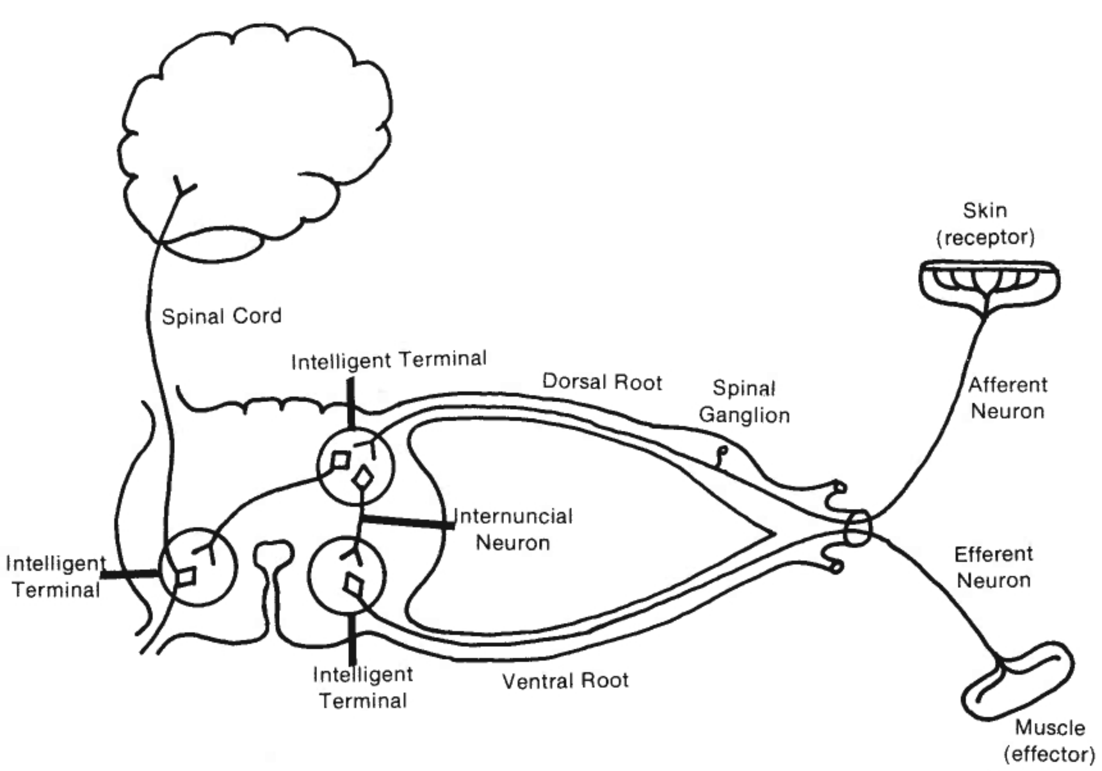
The human body acts similar to a computer in that it has the same basic functions: input, central processing and output. The following discussion attempts to correlate these functions into a meaningful relationship.


CPU
Internal Data
External Environment
Sensory Receptors
Intelligent Terminals
Mini Computers
Spinal Cord
Intelligent Terminals
Storage Memory
Control Unit
Midbrain
Cerebellum or ANS Logic
Muscles & Skin Display

Our input unit would be our sensory collection system via the eyes, ears, nose, taste, touch, and also includes many other receptors within our bodies that collect internal data. Adequate irritation of these receptors is called the stimulus (sensory data) and must be reduced to neurological impulses so that the actual physical event can be translated and presented to the nervous system. These impulses are acted upon by intelligent terminals (synapes), and what can be called mini-computers, where the impulses are detected, corrected, acted upon, or entered for processing at other levels of functioning. In essence, information collected by the sensory system must be directed to the proper areas for adequate processing and integration. Numerous intelligent terminals perform many important functions and simple actions are processed entirely at the level of the spinal cord from input to output, i.e. reflex arc. The brain may receive impulses from a simple reflex arc and may cause other systemic reactions (evaluation), i.e. eyes focus on an object, head turns toward the object, etc. The body then places all this information in storage for future reference. What was once a simple impulse can become a systemic reaction that may have many sites of storage or memory. (See diagram Reflex Arc on the next page)

The CPU is made up of the nervous system and its divisions:
1. Peripheral nerves, 2. Spinal cord, 3. Midbrain and 4. Cerebellum and cerebral tissues.

Once information that was sensory data is reduced to impulses traveling along the nerve, they are acknowledged, integrated, regrouped and prepared for evaluation and storage. "The specific area for storage or memory has not been located, however, evidence suggests that it is incorporated into the structure wherever the stored information is to act."[4] This would lead us to believe that memory is distributed throughout the body.


Skin
(receptor)
Spinal Cord
Intelligent Terminal
Dorsal Root
Spinal Ganglion
Afferent Neuron
Internuncial Neuron
Intelligent Terminal
Efferent Neuron
Intelligent Terminal
Ventral Root
Muscle
(effector)

Complex data must be reduced to decisions in order to monitor heart rate, temperature, blood and tissue PH, nutritional needs, oxidation rates, thyroid function, muscle tone, spinal positioning and protection of injured or diseased tissue and organs etc.

The output or display function concerns itself with presenting the processed information of the CPU in a meaningful form, for it must reflect the central processing unit's evaluation of the problem. This unit of the biological computer is the muscles and the skin of the body. Abnormal muscle function under these circumstances takes on a new and meaningful perspective.

Muscle weakness must be evaluated and interpreted as potentially reflexing the CPU. Thus abnormal thyroid function can be efficiently displayed into the Teres Minor muscle and proper interpretation and treatment can result in resolution of both the thyroid and Teres Minor muscle aberration.

The goal of the organism is to survive a potentially dangerous external and internal environment. Massive data (input) from these areas must be processed, adapted to or reacted upon successfully. Information not received cannot be included in the CPU evaluation.

The complexity of the body necessitates an efficient organization. Apparently it operates on at least four different levels, each being responsible for organizing and monitoring its particular area of functioning with some overlapping into other areas. We call these areas computers of different complexities. They are: 1. The cerebral computer, 2. The glandular or autonomic nervous system computer, 3. The spinal computer and 4. The local computer.

The first or primary computer relates to cerebral activity. It is by far the most complex for it is capable of evaluation, integration and storage far beyond the other levels of function. The secondary computer is called the glandular computer. It regulates most automated functions as well as monitors the Endocrine system. Next, is the tertiary or spinal computer, which is responsible for communication, integration of information, and the chemistry of digestion. The local computer is the most rudimentary and is found in the motor point of each muscle and thought to be in other types of specific tissue. This functions as the display unit of the CPU. (See figure Biocomputer)

Intelligent Terminals

The biocomputer contains many intelligent terminals which are a network of mini-computers or sub-systems in each of the four types of computers - primary, glandular, spinal and local. These terminals are responsible for capturing, correction and monitoring of input information, along with the entering of raw data to primary computers. These terminals also act as mediators between computers, as well as monitors of the cloacals, visual and labyrinthine mechanisms of posture. Information which represents an overload to a more primary computer may be inhibited or put on hold at this level, until this information can be processed successfully. These units are important.

Center Of Man

The biocomputer also has a center from which everything that occurs in the body must be focused. This center is the umbilicus, and has twelve areas that are arranged as a clock and are so labeled. Any changes that occur in any of the computers must be processed through the center of man in order to allow proper integration.

Computer Locations In The Body

Each computer has a primary site or physical representative area in the body. At this site, analysis of proper function of that computer may take place.

K 27

The primary physical location of the local computers (muscles) is an acupuncture point called K27. It is located at the junction of the 1st rib, clavicle and sternum. The kinetic representative of K27 is the two divisions of the muscle, Sternocleidomastoid. Thus head turning is tied to local computer function and K27 identification. The bones related to local computer are the clavicles.

Hyoid

The primary physical location of the spinal computer is Stomach 9, and the hyoid bone. Its kinetic relationship is its primary muscles. They are listed as follows: 1. Anterior belly of digastricus 2. Posterior belly of digastricus, 3. Stylohyoid, 4. Mylohyoid, 5. Geniohyoid, 6. Sternohyoid, 7. Sternothyroid, 8. Thyrohyoid, 9. Omohyoid. Muscles that are directly related to the computer (see 1-9 hyoid muscles) record or store all adaptive information. As display units of each computer, they reflect the status of that computer in time and space.

TMJ

The primary physical location of the Endocrine computer is the temporal mandibular joint (TMJ) and associated tissues. The acupuncture point is St 7. The muscles of the Endocrine computer are as follows: 1. Masseter, superficial division, 2. Masseter, deep division, 3. Pterygoid Internus Medialis, sphenoid division, 4. Pterygoid Internus Medialis, palatine division, 5. Pterygoid Externus Lateral, sphenoid division, 6. Pterygoid Externus Lateral, lower division, 7. Temporalis, parietal division, 8. Temporalis, occipital division.

EYE

The physical location of the primary computer is the eyes and their adjacent musculature. They are as follows: I. Rectus Superior, 2. Rectus Medialis, 3. Rectus Inferior, 4. Rectus Superior Oblique, 5. Rectus Lateralis, 6. Rectus Inferior Oblique, 7. Upper Trapezius, 8. Longus Capitus, 9. Semispinalis Capitus and possibly more. The bones of the cranium are to the primary computer what the vertebrae of the spine are to the spinal column. The acupuncture point of the primary computer is Bladder I.

TO REVIEW:

Each computer represents a level of expression and processing. Each level is capable of input, processing, and output. The hierarchy is set so that the most important decisions are made by computers which are capable of the greatest degree of related computations. Thus problems of an Endocrine nature are handled by the Endocrine computer. Problems of a muscle level are processed at this level also. However, since a muscle is a display unit for the other computers, muscle aberration requires special attention.

KINESIOLOGY

In 1964 Dr. George Goodheart discovered a new diagnostic test for body evaluation. It was called Applied Kinesiology and consisted of muscle testing to evaluate the musculoskeletal status of the patient. Since 1964, the body of knowledge and application of Kinesiology has grown to immense proportions.

Muscle testing is computer evaluation. If interpreted correctly, adequate insight into body signs, symptoms and language are easily processed into meaningful information.

ADAPTATION

In the early stages of disease clear relationships exist between muscles and organs. Thus every thyroid dysfunction demonstrated a weak Teres Minor. Every kidney dysfunction demonstrated a weak Psoas muscle, etc. These decisions are generally a reflection of the strategy of the Endocrine computer. Perhaps at this point in time, all elements necessary for healing of the kidney are not available. The stress in the kidney and Psoas muscle are too great and the organism is threatened. This forces the Endocrine computer into a decision or what may be called an adaptation. The adaptation means in a practical sense that the weight or burden is switched to another organ. In a successful adaptation, frequently the pain or discomfort leaves and the patient may feel better even though the kidney problem still exists. In this case, depending on other variables, the Psoas muscle may return to normal tone. Switched means exactly what it says the burden is delegated to another organ or tissue. Generally this results in a hypertonic organ or muscle related to that organ. To be switched, as is often stated in Kinesiology, indicates a successful adaptation. Kinetic diagnosis made in adaptive stages are less significant. This is why switching technic treatment has become so important. As a disease proceeds in time, generally speaking, the display spreads. The muscle system may show many muscle weaknesses, but are effects of the adaptation rather than the cause.

COMPUTER CLEAR OUT

Frequent observations by Kinesiologists suggest that the number of muscle weaknesses in an area of complaint appear out of proportion to the number of organs actually involved. Certainly not all muscles are reflecting an organ dysfunction. In painful situations, numerous feedback systems and computer adaptations lead to a mass of overriding neurological output which results in multiple muscle aberrations.

The first step in clearing the area is to perform a computer clear out. This means to activate all computers to remove adaptations, establish order and to see the underlying causative factors. If inadequate diagnostic procedure and treatment follow computer clear out, the organism will return to its prior state. Central computer clear out is performed in the following manner:

1. The area of complaint is identified.
2. It must demonstrate a positive Palmer therapy localization. (TL).
3. Test all the muscles of this area and record.
4. Retest all muscles and at the same time, place your thumb in the umbilicus.
5. When you find a positive two point to the thumb, test to find if respiration affects the TL. Follow the non-respiratory lesion (NRL) as your priority.
6. Once you have a positive thumb that two points, find a direction in the umbilicus that two points to the muscle. There are 12 possibilities but generally the point will be toward the area of complaint.

7. Retest your muscle and confirm the direction of the umbilicus contact. You are now prepared to diagnose the rest of the computer clear out.

8. Challenging the Local Computer - K27. Turn the head to the left and right and test. Follow the positive two point. If the direction of the umbilicus was 1-5, the K27 should be positive on the left with the head turned to the right. If the direction on the umbilicus was 7-11, the K27 should be positive on the right with the head turned to the left. Head turning to the opposite side of the positive K27 is activated by the Ipsilateral Sternocleidomastoid. Note your information and place the head again in neutral.

9. Challenging the Hyoid. The hyoid represents the spinal computer. Most of its adaptations are generally stored in the muscles of the hyoid. The most frequent muscle involved is the Stylohyoid muscle and is therefore challenged primarily R-L or L-R. Note your positive two point from the umbilicus and record. Leave the hyoid in neutral and proceed to the TMJ. The hyoid generally moves the same direction as head turning.

10. Challenging the TMJ-Endocrine computer. The muscles of this computer retain the storage of the adaptation. They may be hypertonic or flaccid depending on the circumstances. Most adaptations appear in the muscle Pterygoid Externus activated by opening the jaw and moving it laterally. Find the TMJ position that has a positive two point to the umbilicus contact. Place the TMJ in neutral and proceed to the eyes. The TMJ usually moves opposite to the hyoid on the same side as the umbilicus contact.

11. Challenging the Eyes-Primary computer. The eye is usually found positive on the same side as the TMJ. Activate each of the eye muscle groups and follow the one which has a positive two point to the umbilicus.

COMPUTER CLEARING TECHNIC (CCT)

I. Hold the proper direction at the umbilicus.

2. Turn the head to the opposite side of diagnosed K27.

3. Place the patient's hand on the hyoid bone and push in the proper direction.

4. Move the jaw to the diagnosed position.

5. Activate the eye muscle of the patient in the proper position and hold all of the above.

6. The treating doctor now holds the umbilicus direction and taps or rubs the correct K27 and waits for harmonious pulsations. This should take 30 seconds to one minute and at the most two minutes.

PROBLEMS

1. If a harmonious pulse is not felt in one minute, note the positions of all computer units and if necessary confirm previously diagnosed positions.

2. Contact acupuncture points or computers and bridge between umbilicus and St 9 (hyoid), St 7 (TMJ) and B1 (eye). Wait for pulsation.

The intent of the CCT is 1. To allow proper regrouping of the individual computers. 2. To allow the CPU the opportunity to reevaluate the output units and properly display the more direct causative factors. 3. Adaptive information is reassessed.

PRACTICAL APPLICATION

A Kinesiology exam of the area of complaint usually results in multiple muscle weaknesses. Following the CCT, the compensatory muscles are normalized and the primary muscles or conditions of malfunction are left to evaluate.

With the above understanding, a new conceptualization of disease may be presented. Disease can be represented as:

1. Breakdown in communications.
2. Conflict in strategies between levels of functions or computers.
3. Circuit overload.
4. Circuit erosion.
5. Inadequate input for adequate resolution.
6. Inadequate transferring of information, nutritional deprivation, RNA, neurotransmitters, etc.
7. Priority of CPU not recognized by treating physicians.
8. Abnormal input from oral cavity, i.e. suppressive drugs etc.
9. Computer processing at full capacity and therefore data put on hold.
10. Compartmentalization of aberrant tissue.

The CCT has performed miracles in data reduction and has facilitated diagnosis, and therefore patient response. It is presented for your patient's benefit.

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Spencer, Donald D., Computers in Action. Hayden Book Company, Inc. Rochelle Park, N.J. 1978.

PROCEDURE FOR MUSCLE CORRECTION

On a local basis a muscle is directly influenced by one or more of the following factors:

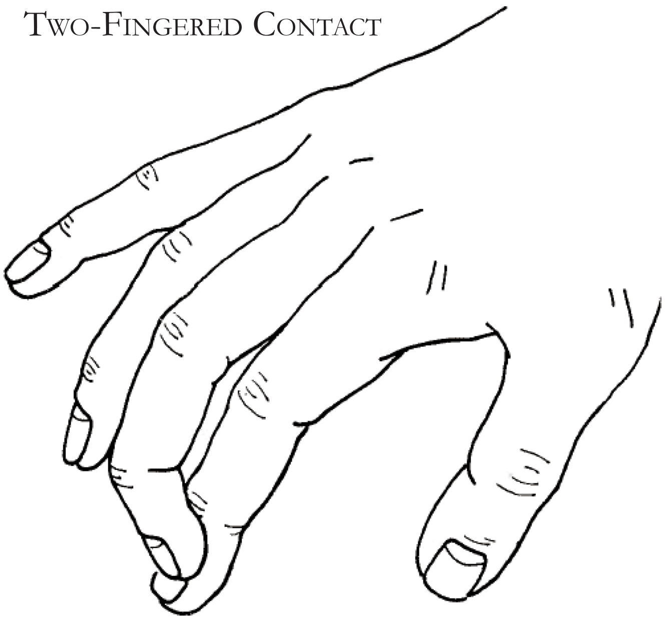
1. Neurovascular
2. Neurolymphatic
3. Visceral Organ Reflex
4. Muscle Acupuncture Point
5. Vertebral Level and Myomere
6. Cranial
7. Nutrition

SYNCHRONOUS PULSE AND DOUBLE FINGERED CONTACT

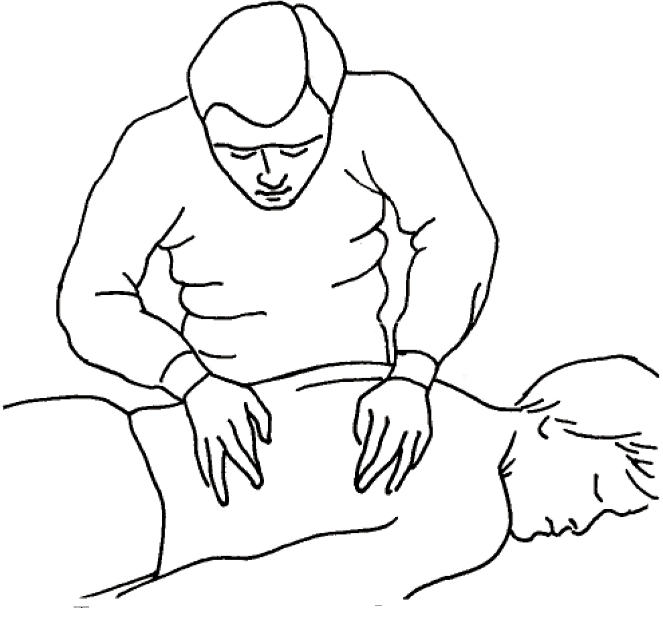
Based upon clinical experience over many years and trial and error testing of many techniques, certain procedures have remained dominant as being the most effective when treating a muscle on a local basis. This procedure is the use of a double-fingered bilateral contact. (See diagram). The contact is held until a synchronal pulse is felt.

While stimulating any reflex point on the body, always use a two-fingered contact. (See diagram). This is a neutral contact as opposed to a positive or negative single finger contact.

TWO-FINGERED CONTACT



DOUBLE-FINGERED BILATERAL CONTACT



NEUROVASCULAR (NV):

Vascular beds of the muscle needing treatment are influenced by using the following procedure until a synchronous pulse is felt (See Synchronous pulse and Double Fingered technique). A neurovascular reflex, which is generally located on the surface of the cranium, when activated by a light tugging double-fingered contact with one hand and a rotary stimulating contact with the opposite hand at the origin of the muscle, will restore normal circulation to the area associated with that reflex. These contacts are ipsilateral.

Neurolymphatic (NL):

The lymphatics of the muscle being treated are influenced by using the following procedure until a synchronous pulse is felt. A Neurolymphatic reflex, which is generally located in the rib cage, when activated by a rotary-stimulating contact with one hand and a rotary stimulating contact with the opposite hand at the insertion of the muscle, will produce lymphatic flushing of the areas associated with that reflex. Both the right and left muscle group are treated by using the same reflex.

Visceral Organ Reflexes (VOR I and VOR II):

Somato-visceral influences and viscero-somatic reflexes are common feedback systems with the local computer. A muscle is primarily associated with two specific organs. They are listed as Visceral Organ I (VOR I) and Visceral Organ II (VOR II) and are treated as follows.

A VOR, which is generally located on the abdomen or other specific areas of the body, when activated by a rotary stimulating contact with one hand and a rotary stimulating contact with the opposite hand on the Muscle Acupuncture Point, will restore normal interaction between somato-visceral and viscero-somatic functions of the body. Following stimulation hold until a synchronous pulse is detected.

Muscle Acupuncture Point (MAP):

Each muscle has a specific acupuncture point located on the opposite side, which acts as an energizer and a point of circuitry overload, located within or around the normal acupuncture points as previously described by Felix Mann. (For treatment procedure of the MAP see VOR reflex treatment above).

Occasionally the acupuncture point is activated and directly pulsed into the belly of the muscle. This occurs when the MAP two points but neither of the VOR's two-point to the muscle.

Vertebral Level (Vl) And Myomere (Mm):

There are two primary areas of neurological input from the spinal cord to each muscle. The first area is called the myomere and reflects areas of normal neurological innervation to a specific muscle. The vertebral level is a phenomenon not clearly understood but is frequently found associated with each muscle aberration. When either of these levels two-point, adjust those areas as indicated, tap for recall. Occasionally it is necessary to pulse the MM or VL or both to the muscle and to each other. CRANIAL: Adjust with full respiration phase. (See cranial adjusting section.)

Lovette Brother

The Lovette Brother is a vertebral subluxation which occurs on the same side as the Vertebral Level subluxation. A compensatory spinal adaptation and is commonly found associated with each muscle aberration. Treatment procedures include adjusting both the Vertebral Level and its associated Lovette Brother subluxation.

CRANIAL

Related extraspinal subluxation that occurs as a compensatory involvement in muscle aberration.(See Cranial adjusting section, Page 99)

FOOT

Related extraspinal subluxation that occurs as a compensatory involvement in muscle aberration. Treatment procedures is to adjust associated foot subluxation.

NUTRITION:

Each muscle has a specific nutrient associated with it. Nutrition is indicated when the NL point is NOT an NRL and the insertion of the muscle IS an NRL.

PRIORITY TREATMENT

1. Test and record all weak muscles.
2. Use computer clear out technique (See section on The Living Computer).
3. Retest the muscles to determine which one remained weak.
4. The weak muscle is considered a ONE-POINT.
5. Mark the major reflexes associated with the muscle: NV, NL, VOR I, VOR II , VL, MM, Cranial, Foot, and Lovette Brother
6. Have the patient therapy localize (TL) each reflex point while testing the muscle. The reflex that causes the weak muscle to become strong is considered the TWO-POINT.
7 Check the TWO-POINT reflex to make sure it is a NRL.
8. Treat the reflex that is the NRL in the appropriate manner. (See procedure for muscle correction).

NV - Origin
NL - Insertion
MAP - VOR I
MAP VOR II
MAP - Muscle
VL - Adjust, then pulse to MM or muscle a Lovette Brother
MM - Adjust, then pulse to VL or muscle a Lovette Brother
Cranial
Foot

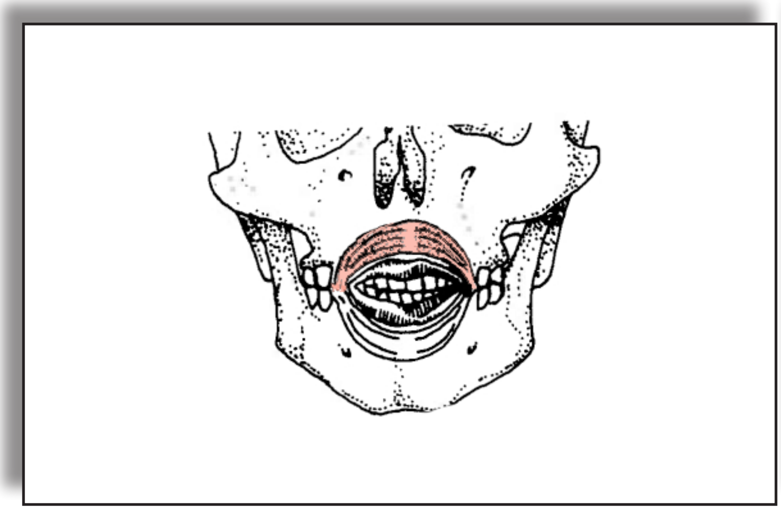
9. If two reflex points are indicated as NRL's, use the THREE-POINT technique. The three point technique helps to determine which of the major reflexes is to be treated. The procedure is as follows:
   a. The weak muscle is the ONE-POINT.
   b. The reflex point that strengthens the muscle is the TWO-POINT.
   c. While the patient TL's the reflex point that strengthened the weak muscle, if any other reflex point changes the indicator muscle, it is considered the THREE-POINT and the major point to be treated.

CHAPTER II:

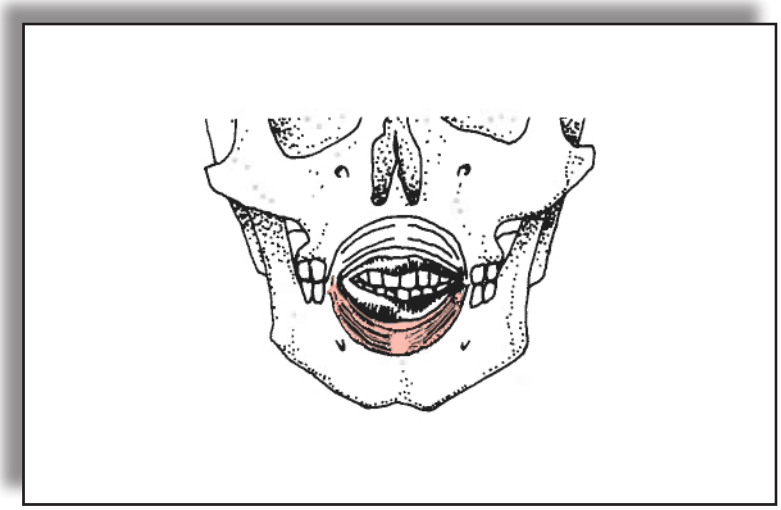
KINESIOLOGICAL TESTING AND EXAMINATION PROCEDURE

GROUP I

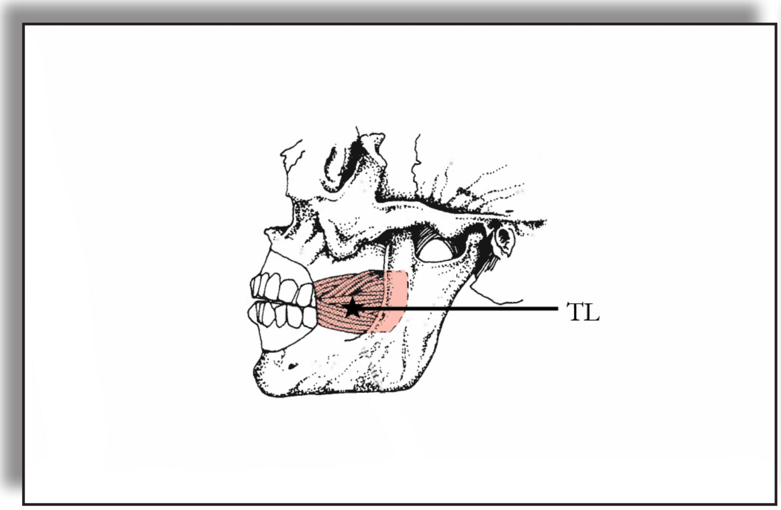
Muscle Testing of TMJ, Hyoid and Other Cervical Muscles



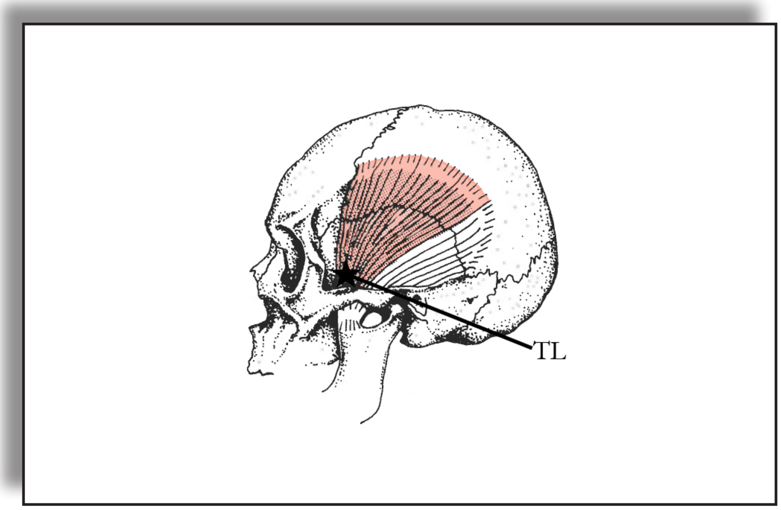
098 Orbicularis Oris, Upper Division



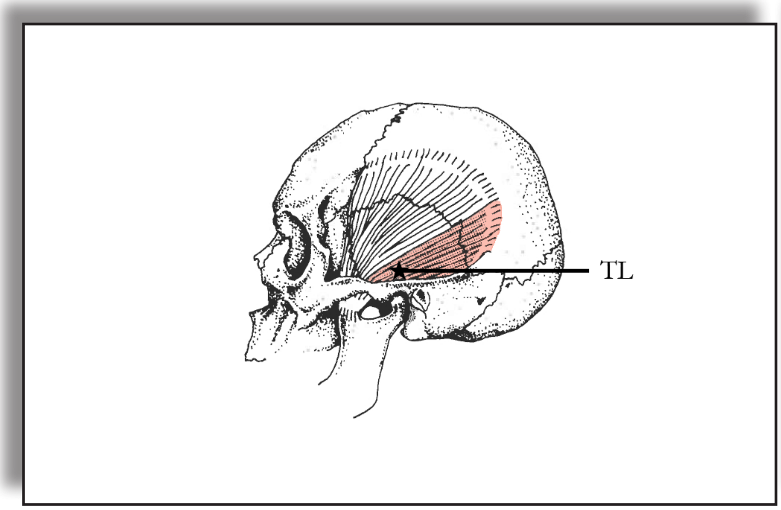
100 Orbicularis Oris, Inferior Division



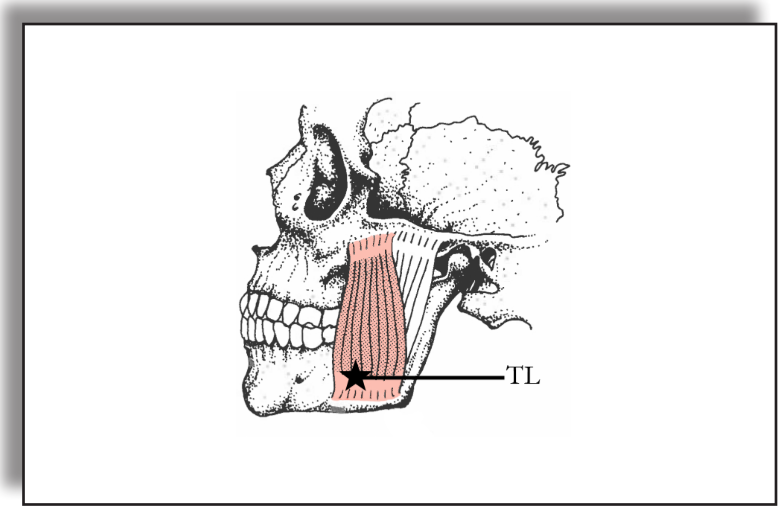
102 Buccinator



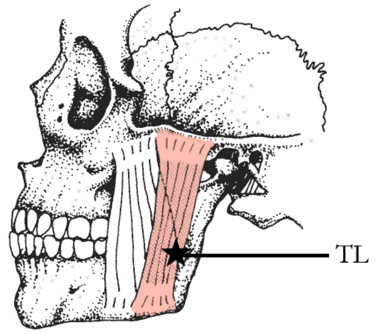
110 Temporalis, Parietal Division



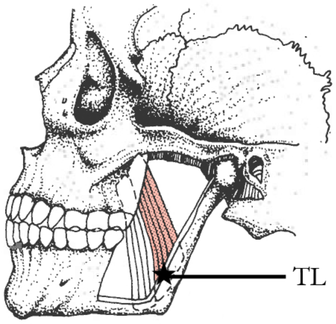
112 Temporalis, Occipital Division



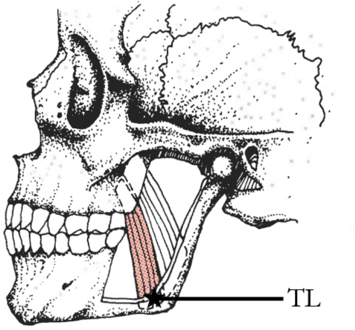
114 Masseter, Superficial Division



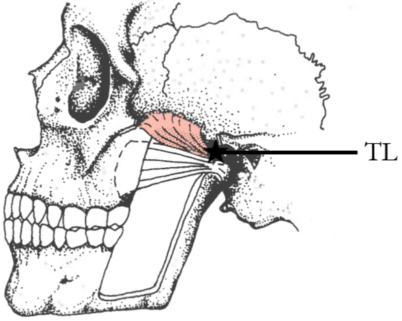
118 Masseter, Deep Division



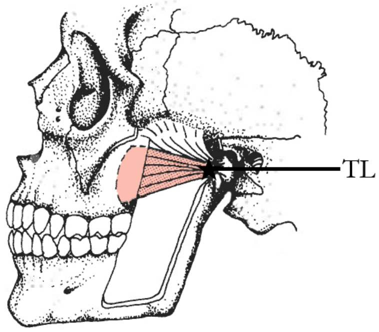
120 Pterygoid Internus Medialis, Sphenoid Division



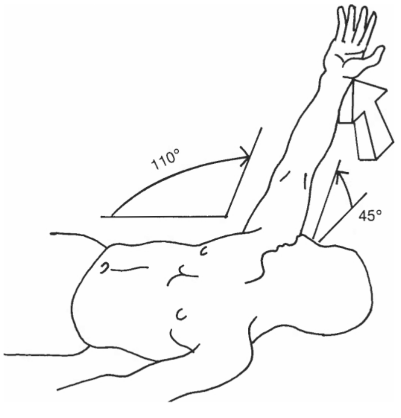
122 Pterygoid Internus Medialis, Palatine Division



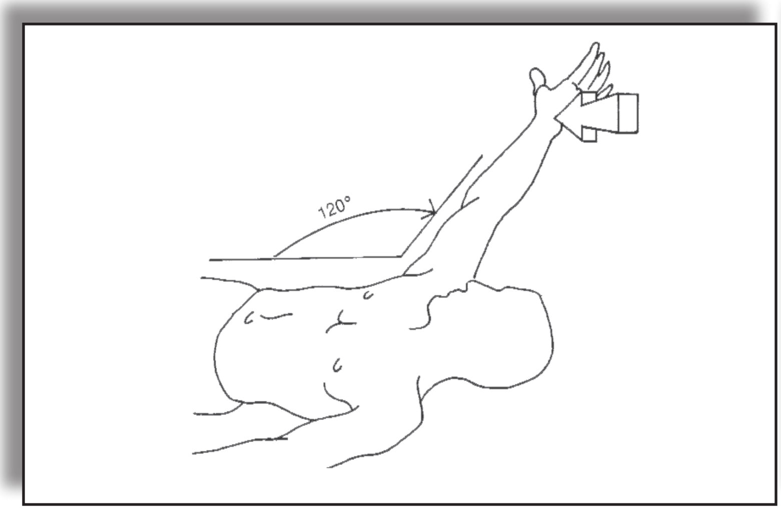
124 Pterygoid Externus Lateralis, Sphenoid Division



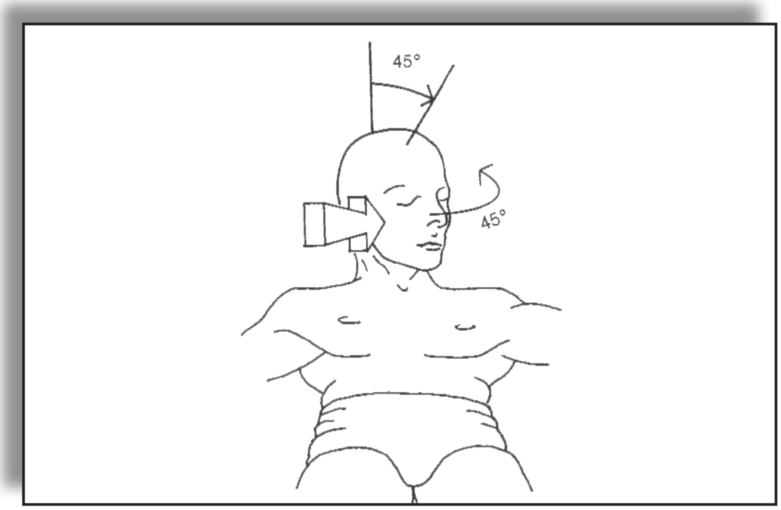
126 Pterygoid Externus Lateralis, Lower Division



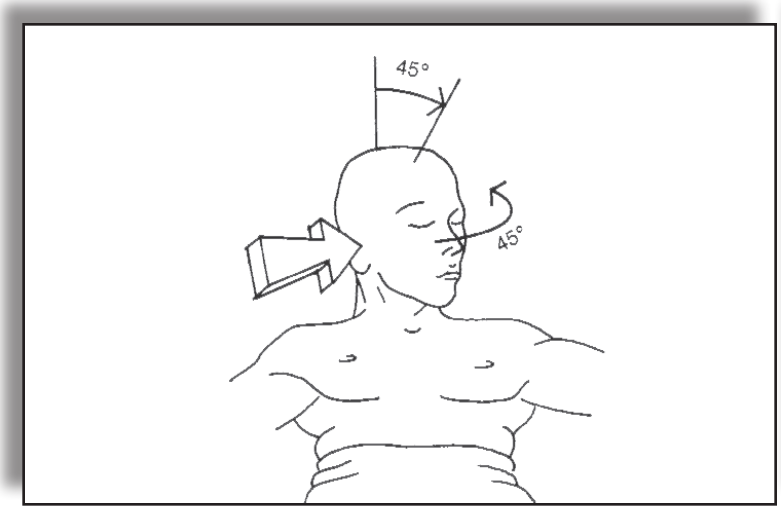
270 Upper Trapezius, Scapular Division



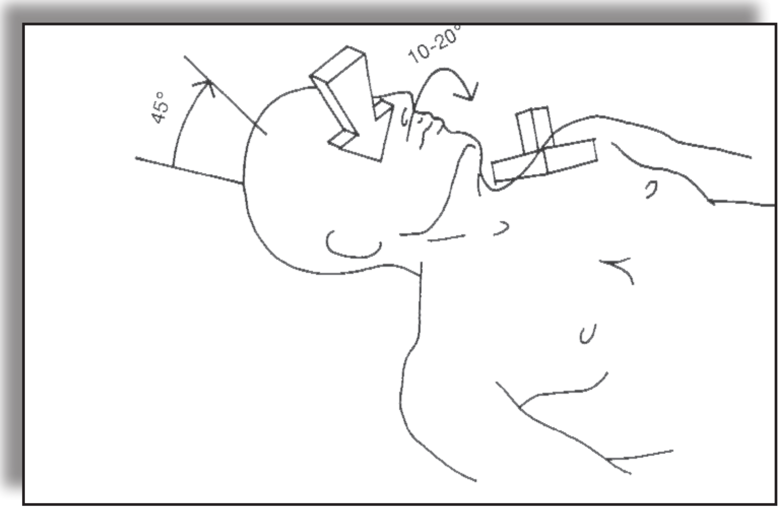
272 Upper Trapezius, Clavicular Division



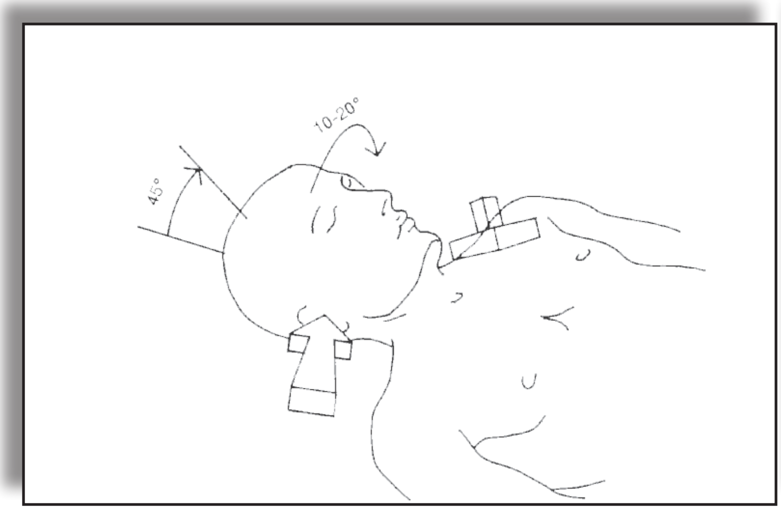
274 Sternocleidomastoid, Sternal Division



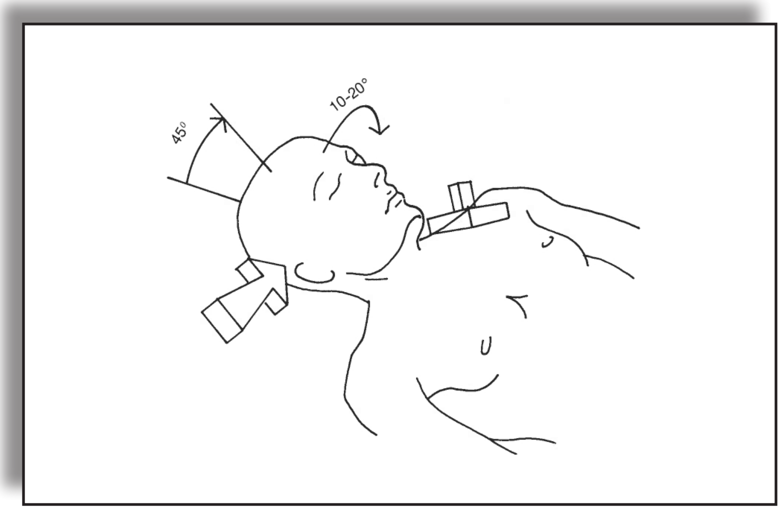
276 Sternocleidomastoid, Clavicular Division



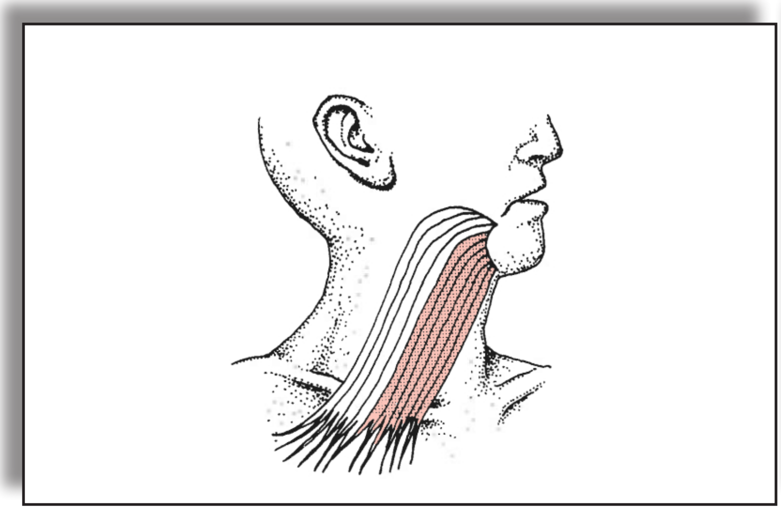
278 Scalenus Anterior



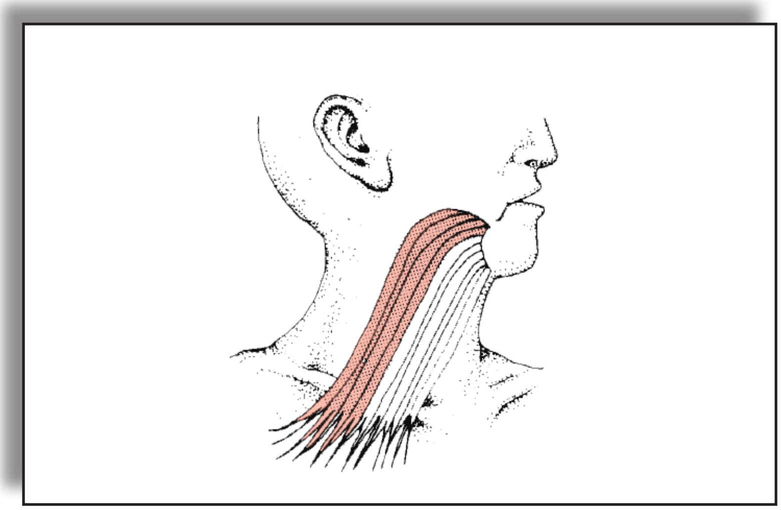
282 Scalenus Medius



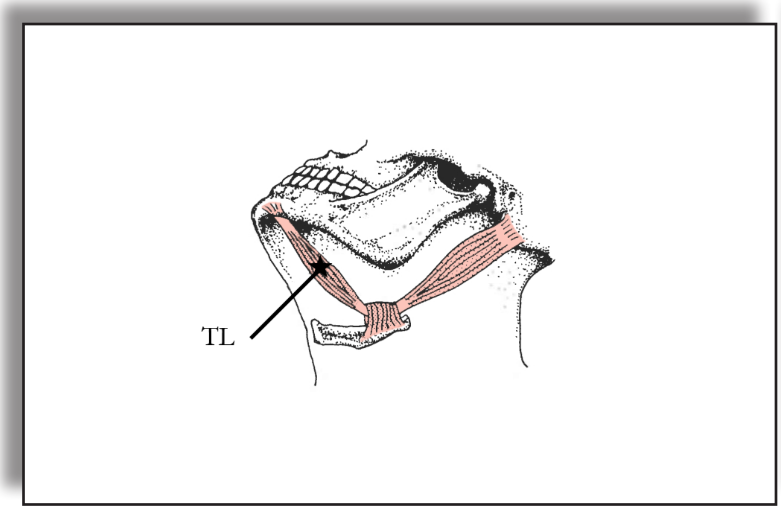
284 Scalenus Posterior



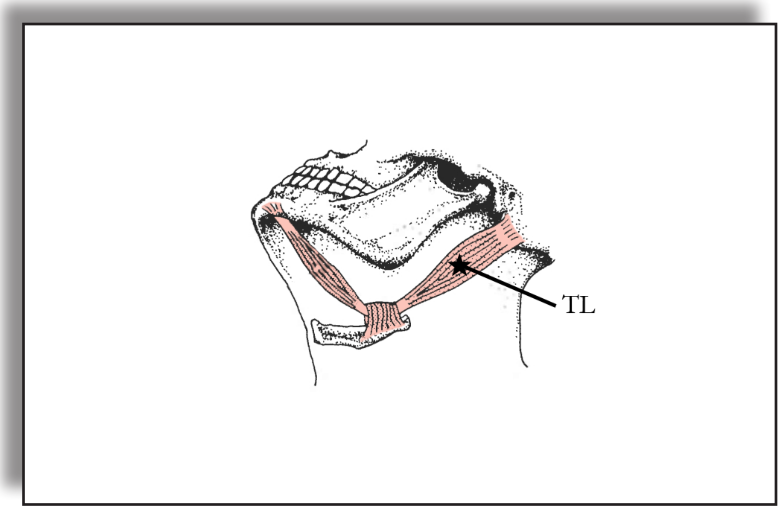
286 Platysma, Anterior Division



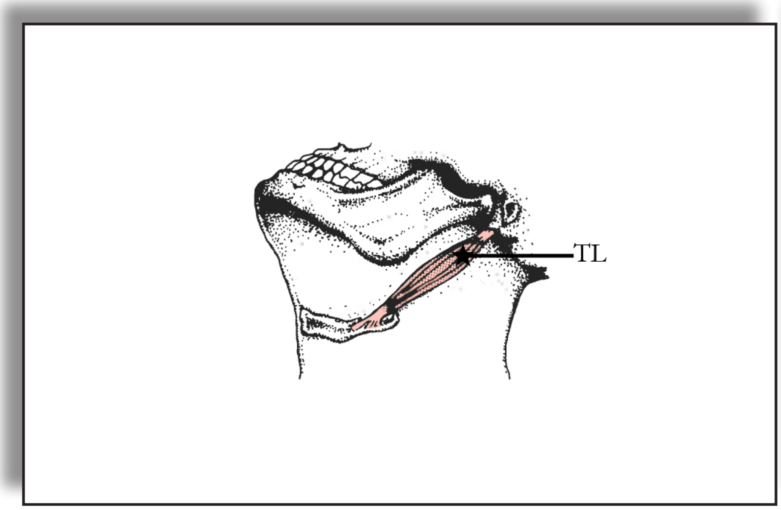
288 Platysma, Posterior Division



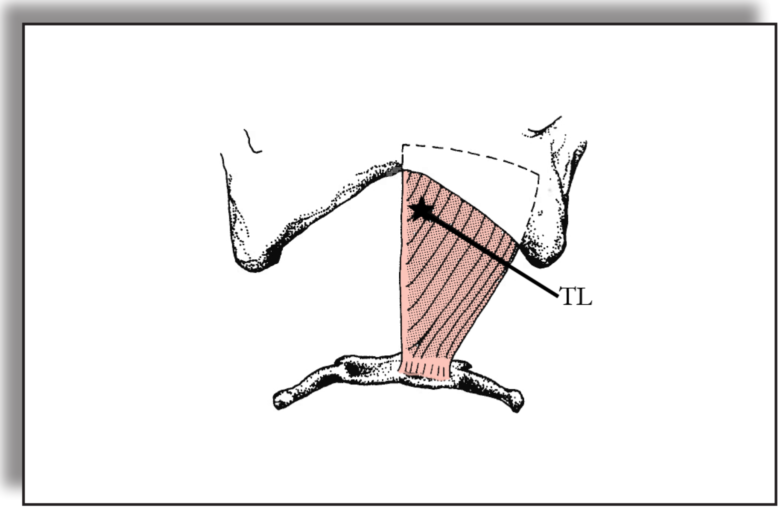
290 Digastric, Anterior Belly



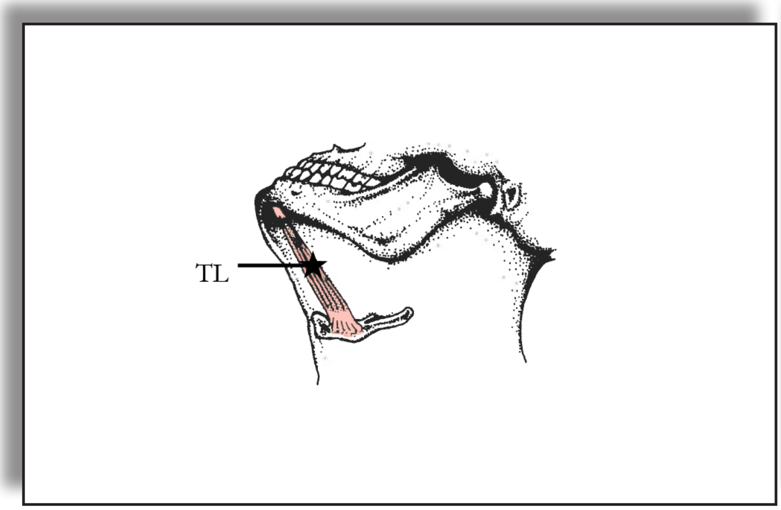
292 Digastric, Posterior Belly



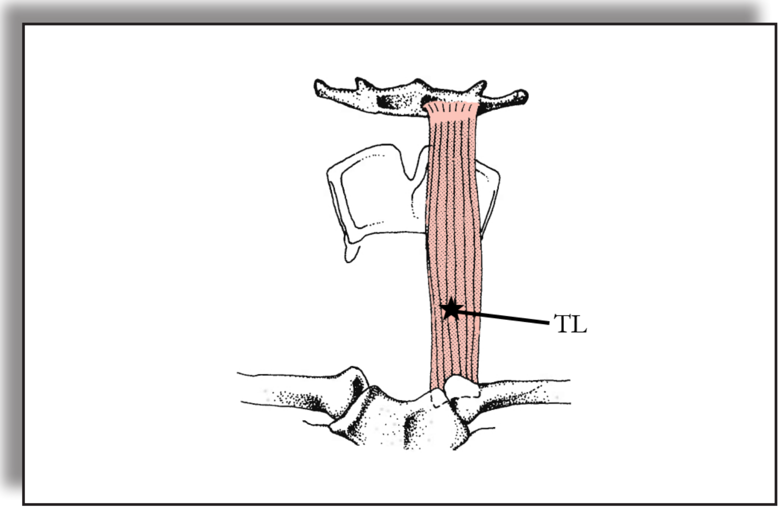
294 Stylohyoid



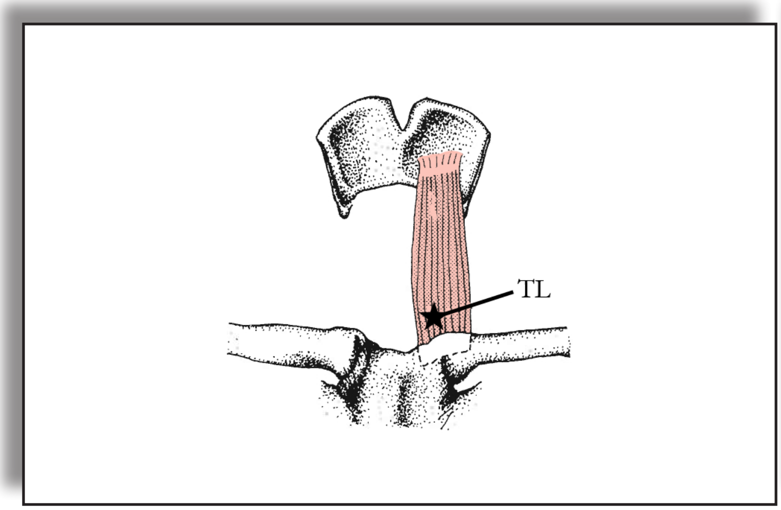
296 Mylohyoid



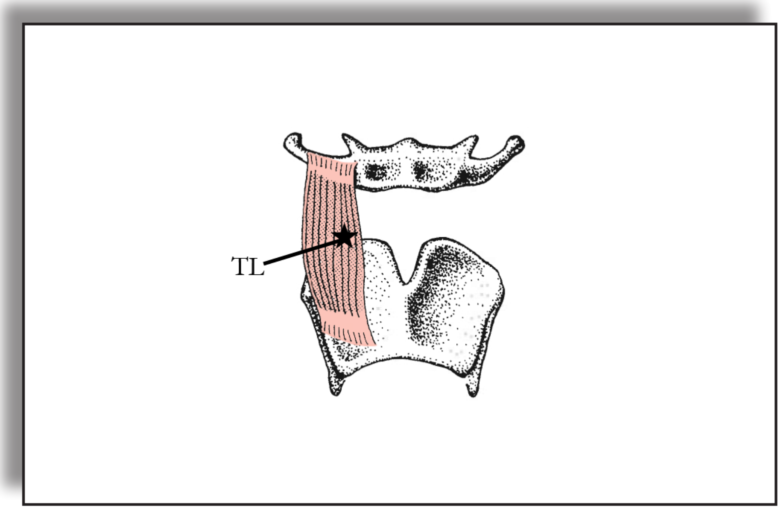
298 Geniohyoid



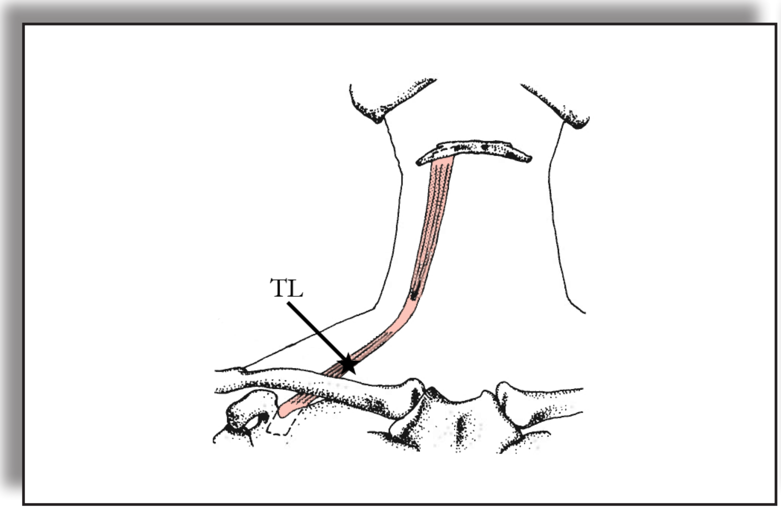
300 Sternohyoid



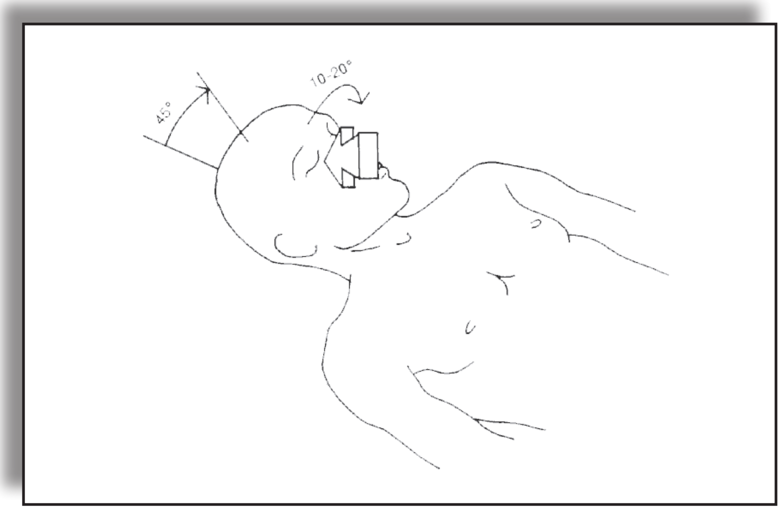
302 Sternothyroid



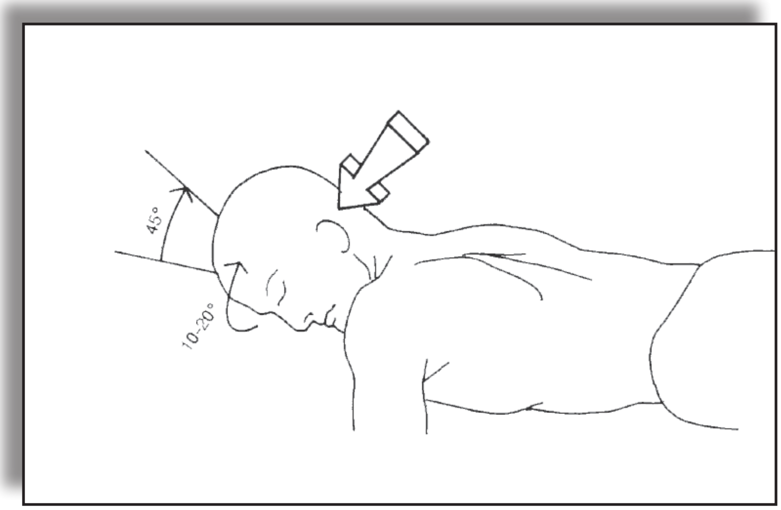
304 Thyrohyoid



306 Omohyoid



314 Longus Capitus



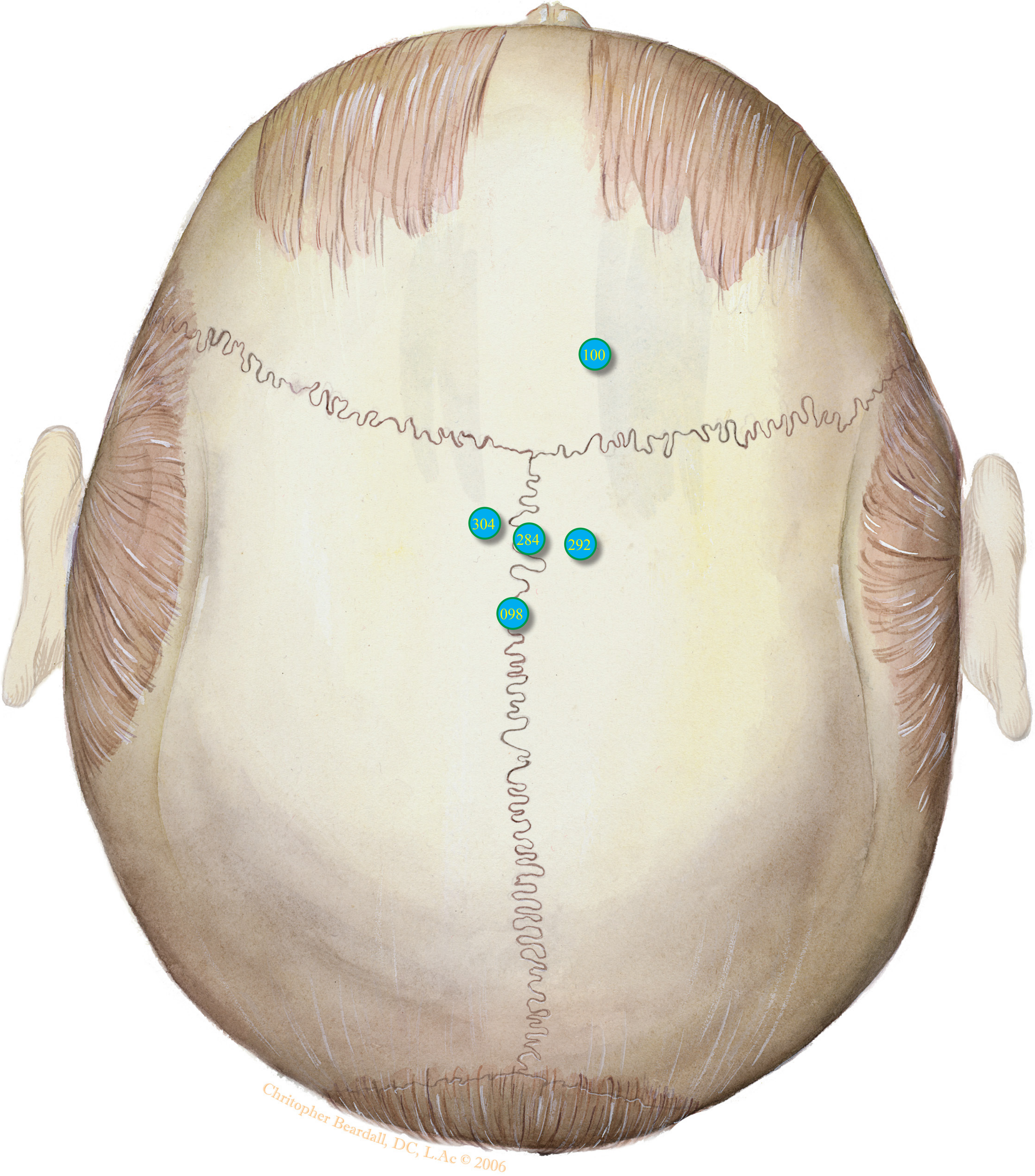
332 Semispinalis Capitus

CHAPTER III:

REFLEXES

Cranial Reflexes

Superior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● Neurovascular Reflex

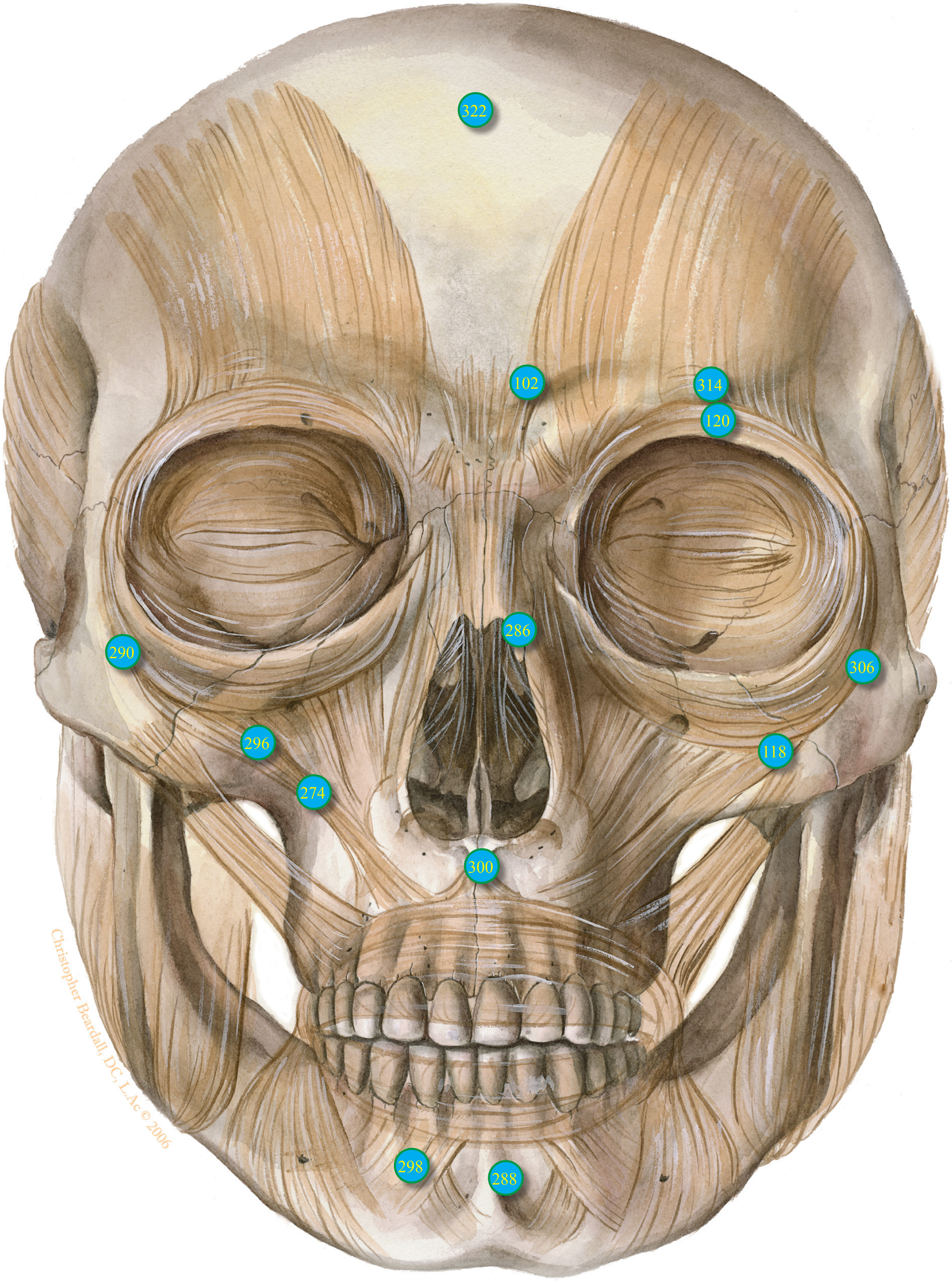
⬭ Neurolymphatic Reflex

⬟ Acupuncture Reflex

▬ Visceral Organ Reflex

Cranial Reflexes

Anterior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● Neurovascular Reflex

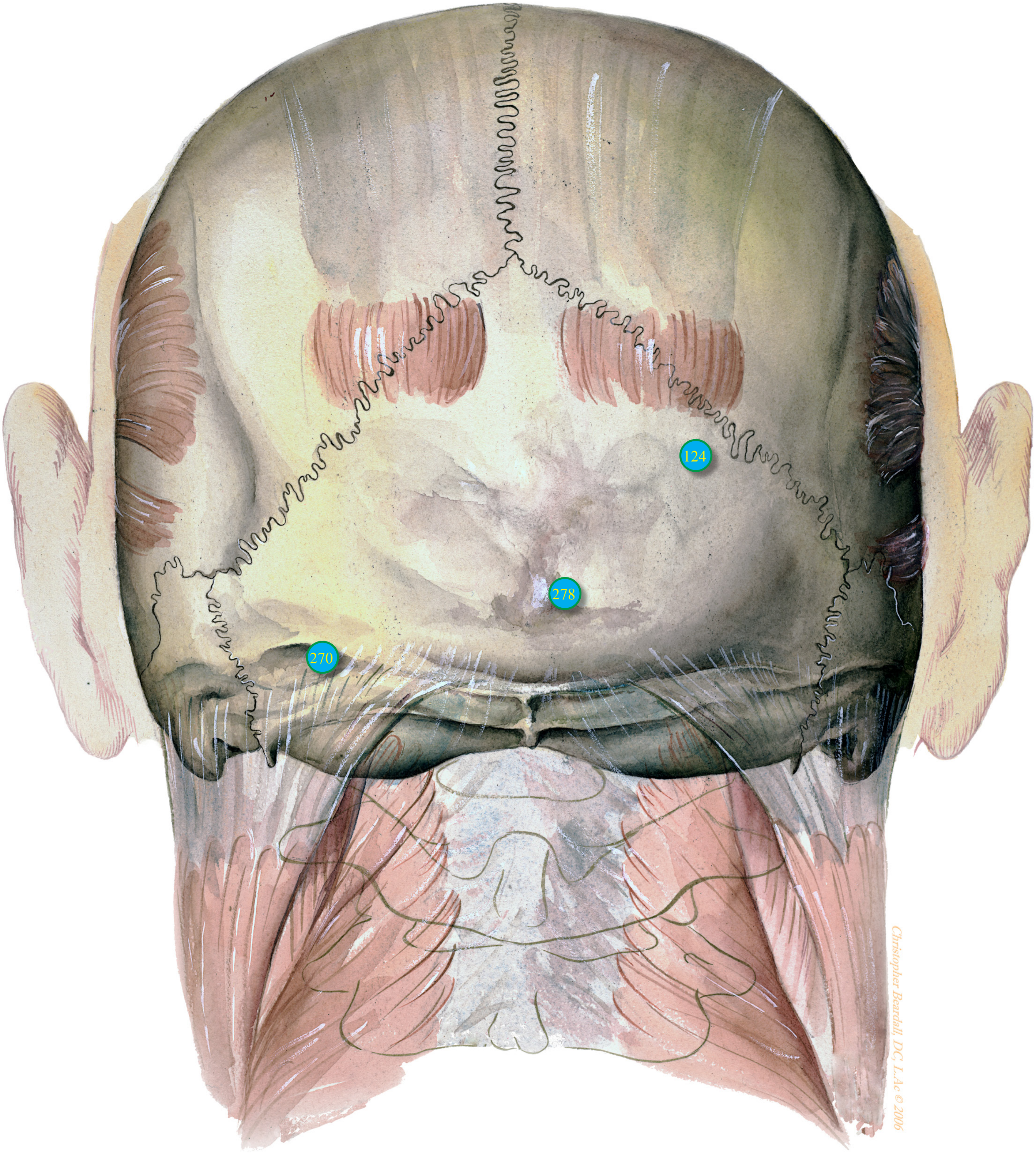
⬬ Neurolymphatic Reflex

⬟ Acupuncture Reflex

▬ Visceral Organ Reflex

CRANIAL REFLEXES

POSTERIOR



Christopher Beardall, DC, L.Ac © 2006

● NEUROVASCULAR REFLEX

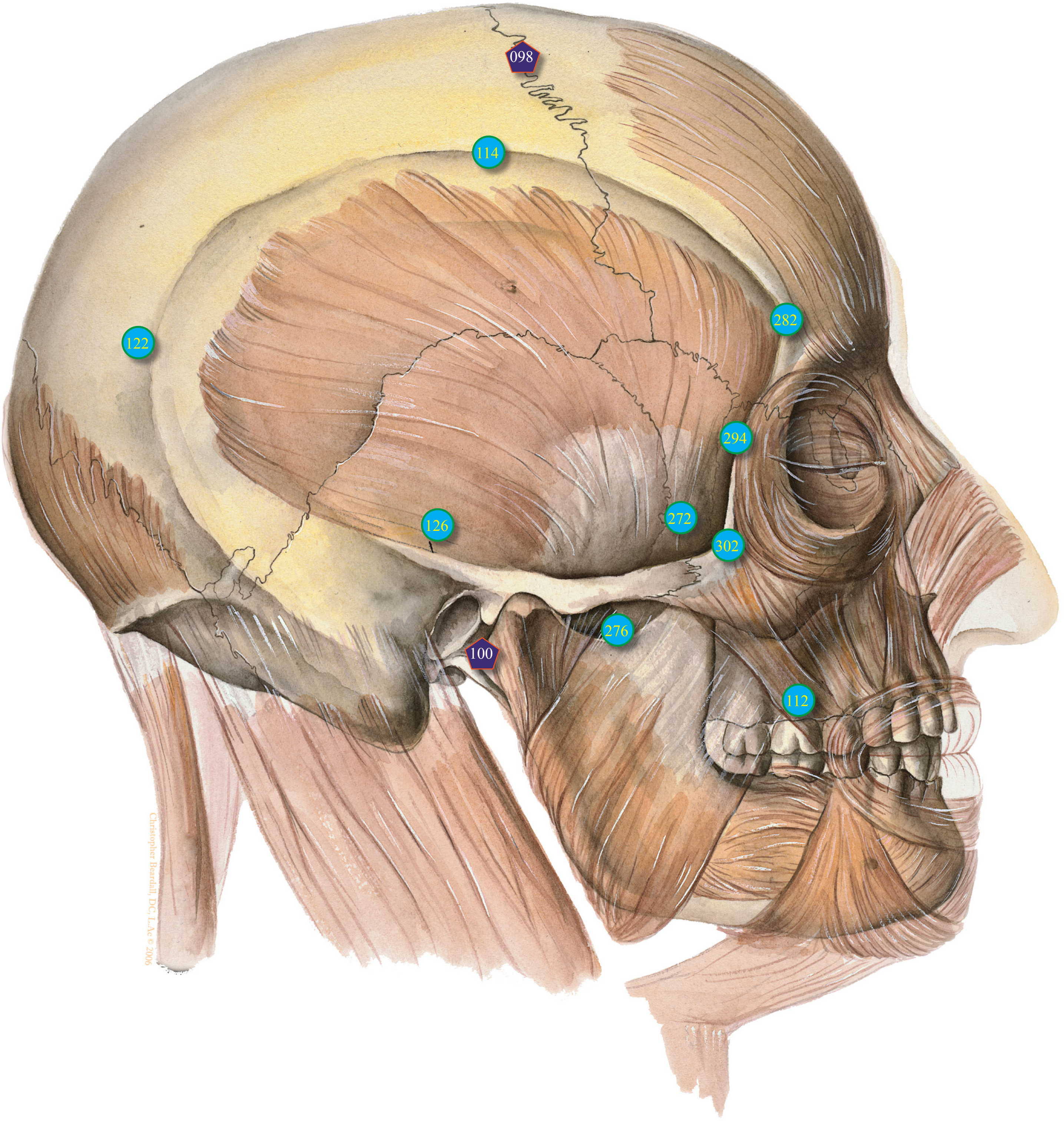
⬭ NEUROLYMPHATIC REFLEX

⬟ ACUPUNCTURE REFLEX

▬ VISCERAL ORGAN REFLEX

Cranial Reflexes

Right Lateral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Christopher Beardall, DC, L.Ac © 2006

● Neurovascular Reflex

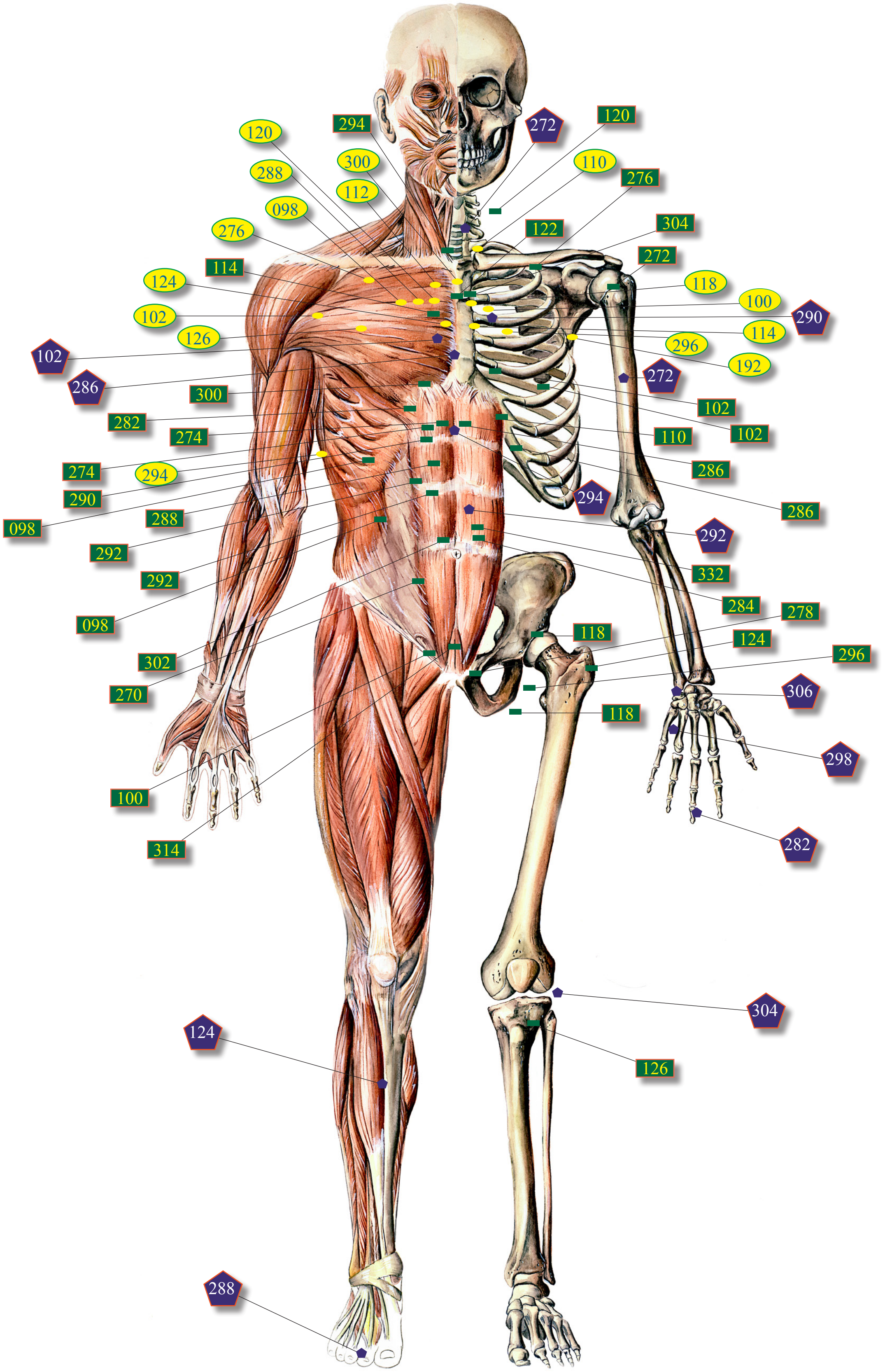
⬭ Neurolymphatic Reflex

⬟ Acupuncture Reflex

▬ Visceral Organ Reflex

Body Zone Reflexes

Anterior



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🔵 Neurovascular Reflex

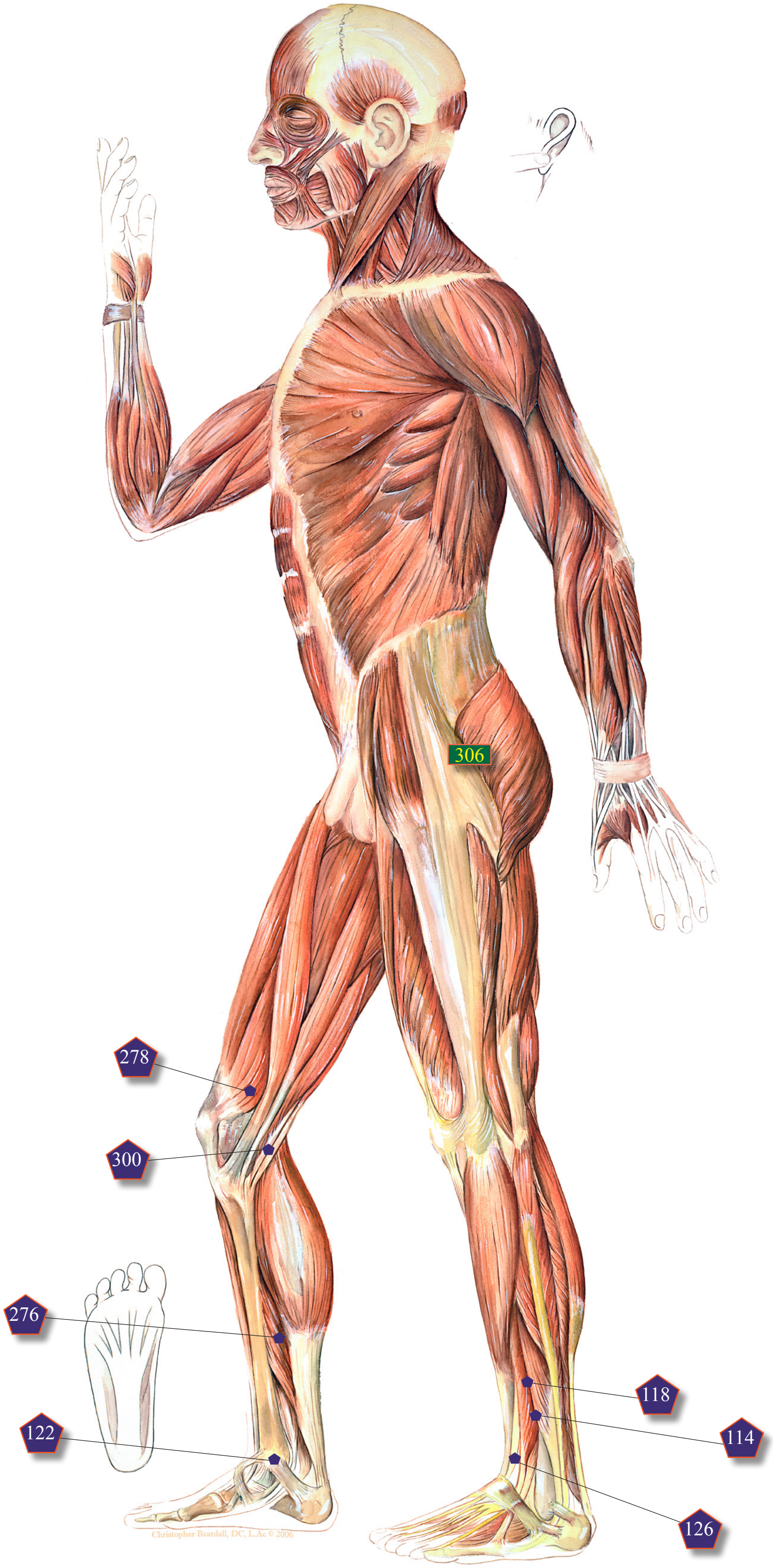
🟡 Neurolymphatic Reflex

⬟ Acupuncture Reflex

🟩 Visceral Organ Reflex

BODY ZONE REFLEXES

LATERAL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● NEUROVASCULAR REFLEX

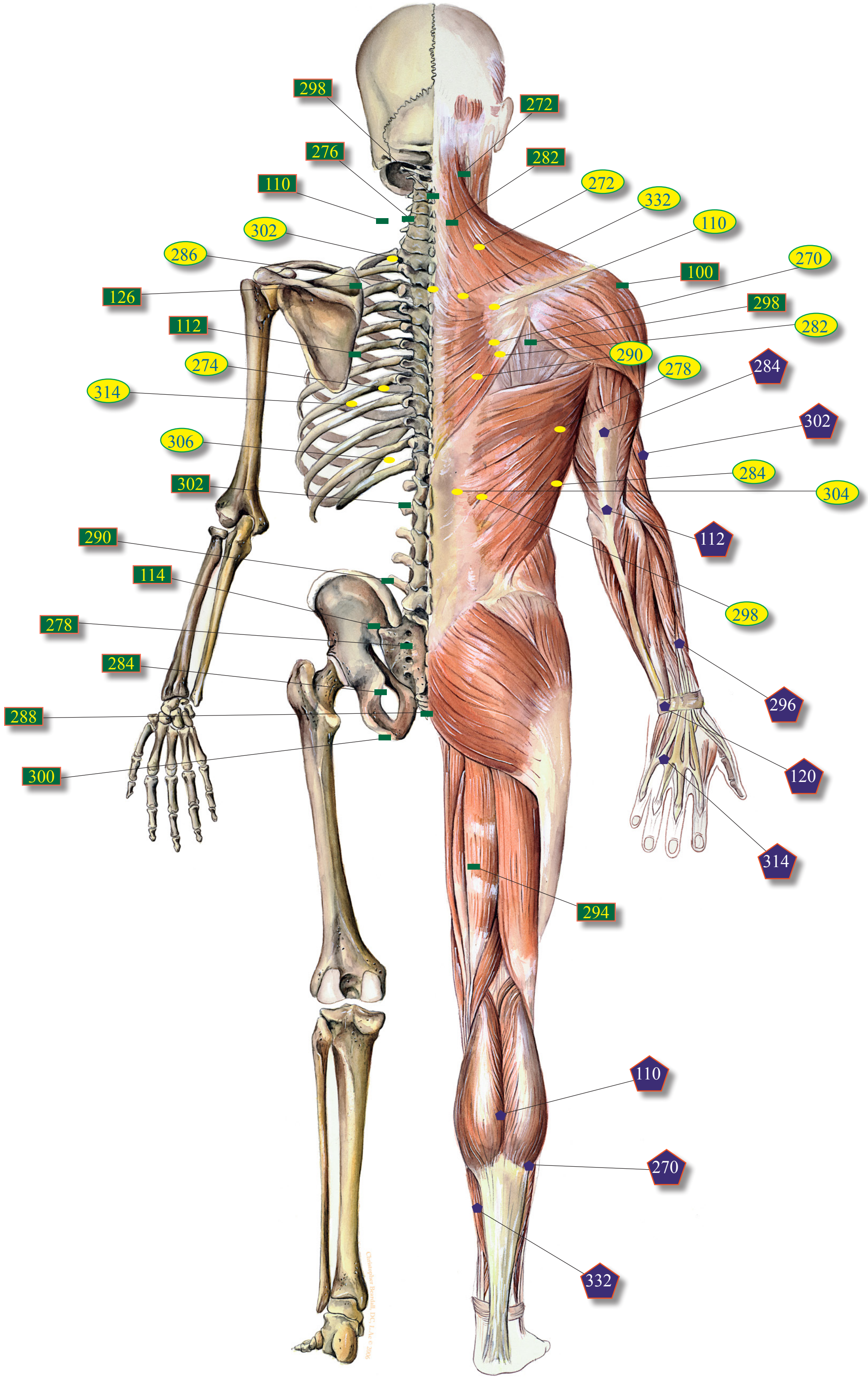
⬭ NEUROLYMPHATIC REFLEX

⬟ ACUPUNCTURE REFLEX

🟩 VISCERAL ORGAN REFLEX

BODY ZONE REFLEXES

POSTERIOR



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🔵 NEUROVASCULAR REFLEX

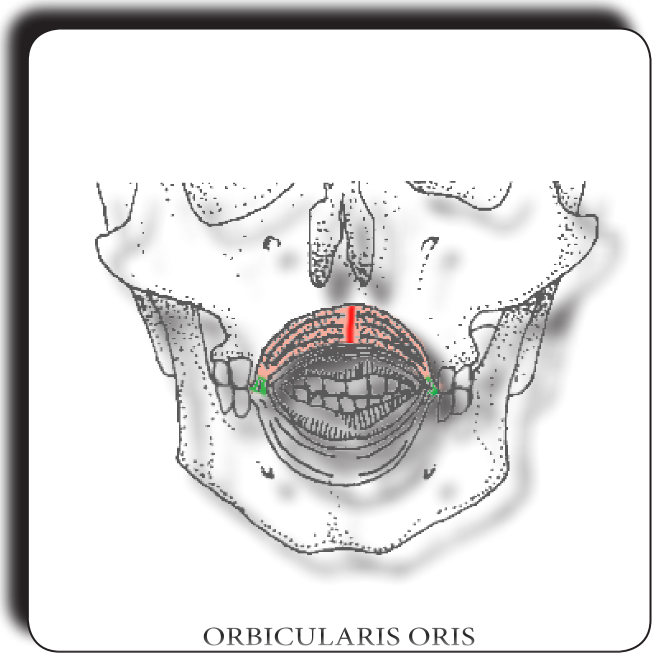
🟡 NEUROLYMPHATIC REFLEX

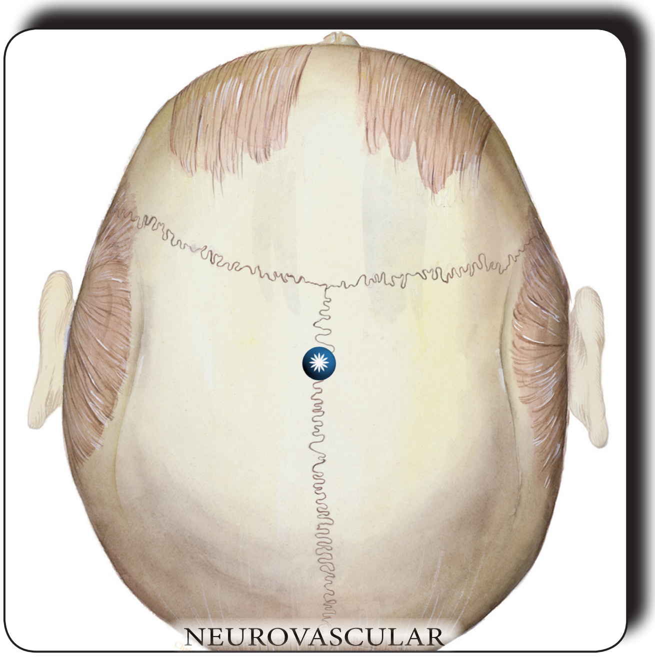
⬟ ACUPUNCTURE REFLEX

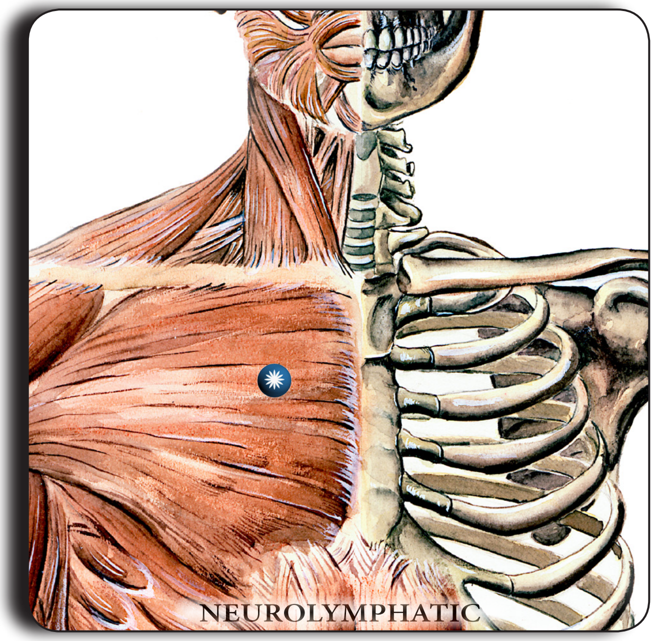
▬ VISCERAL ORGAN REFLEX

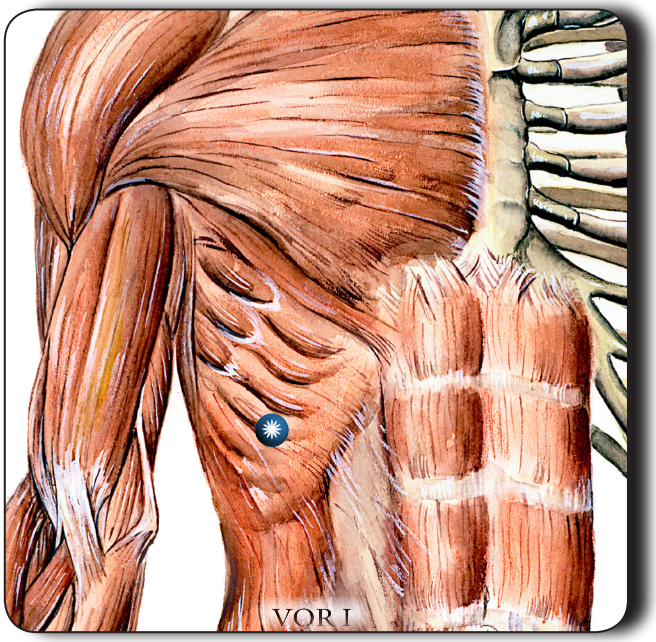
CHAPTER IV:

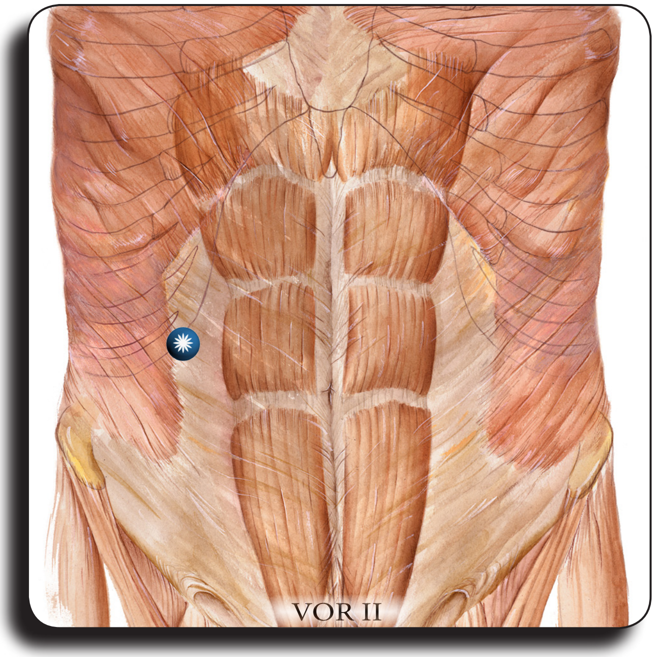
TMJ, HYOID AND OTHER CERVICAL MUSCLES INCLUDING CRANIAL MANIPULATION

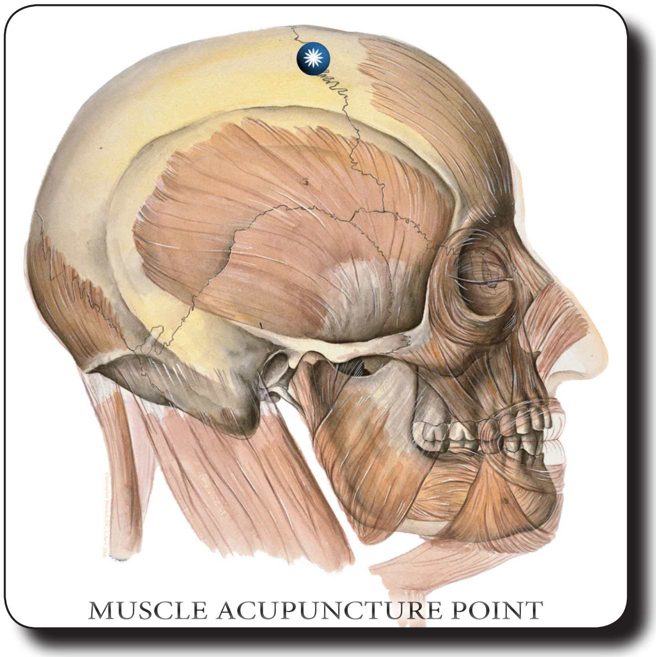

ORBICULARIS ORIS


NEUROVASCULAR


NEUROLYMPHATIC


VOR I


VOR II


MUSCLE ACUPUNCTURE POINT

Muscle 098: ORBICULARIS ORIS, (Upper Division)

ORIGIN: Arises from many facial muscles but primarily from the maxillae bone, above and near the incisirus superior.

INSERTION: Into itself primarily. Treatment area is halfway between GV 27 and ST 4.

ACTION: Compression, contraction, and protrusion of upper lip.

TEST:
Hold bottom lip apart with your fingers. Contract upper lip (kiss position). Test intact muscle before and after. Note change.

NEUROVASCULAR: (Sup/Midline) Sagittal Suture - 1/2" posterior to anterior fontanel.

NEUROLYMPHATIC: (Ant/R) 2nd ICS, 1" lateral to sternum and protrusion of upper lip.

VISCERAL ORGAN:

I. Liver: (Ant/R) 8th rib costocartilage junction

II. Gallbladder: (Ant/R) Arteries 1/2" lateral to mid-belly of 2nd section of Rectus Abdominus 3" Lateral to midline.

M. A. P. : B6

V.L. : C3R

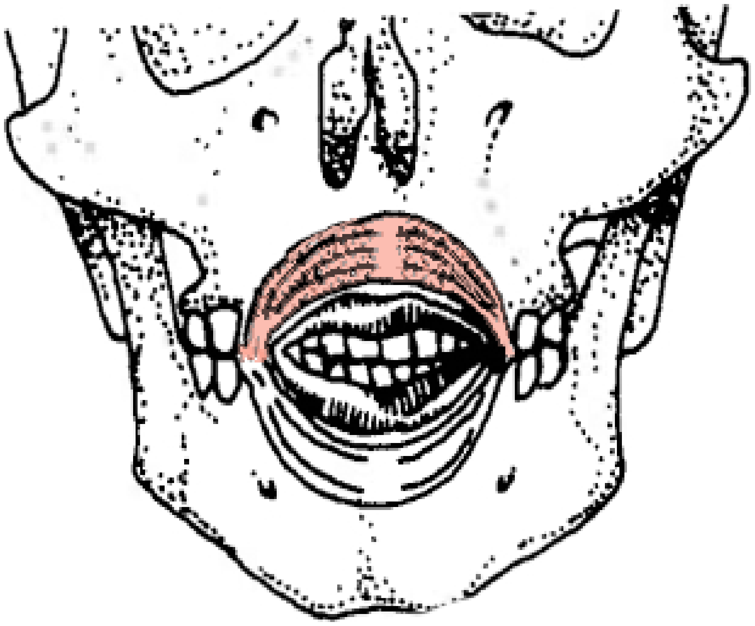
L. B. V.L. : L3R

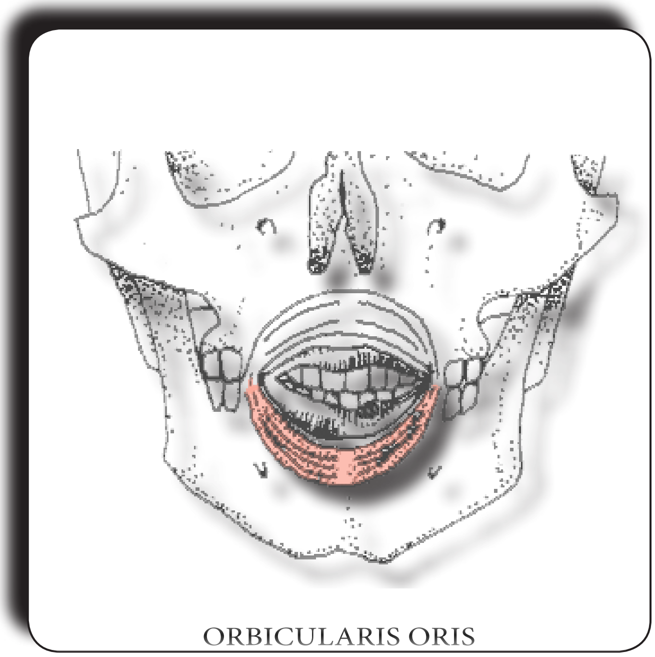
M. M. : CN VII

CRANIAL: Parietal Descent

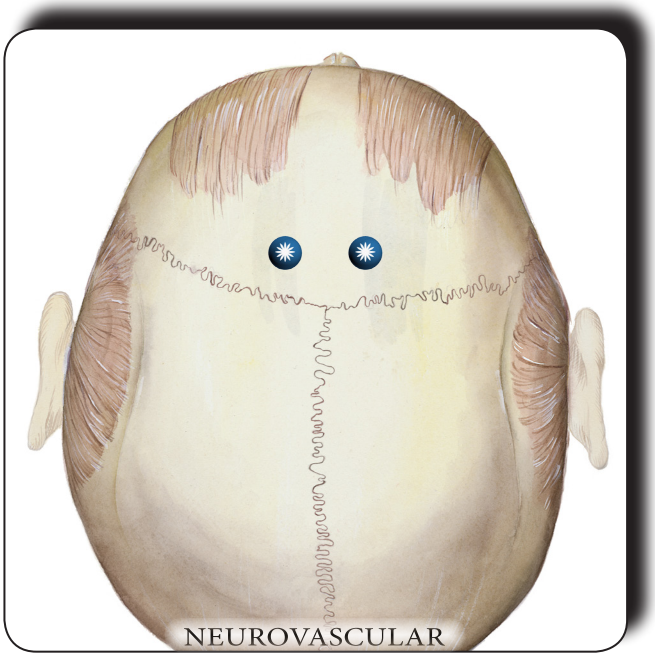
FOOT: Talus

NUTRIENT SOURCE: Manganese
1. Core Manganese (NW)

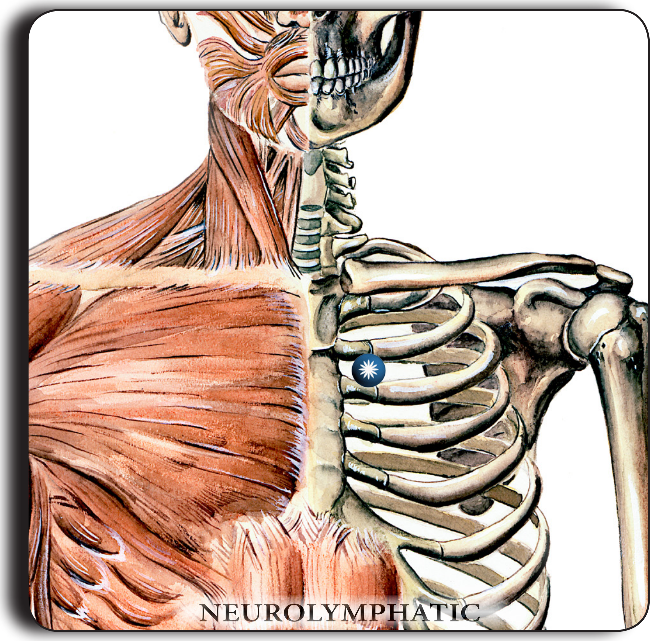




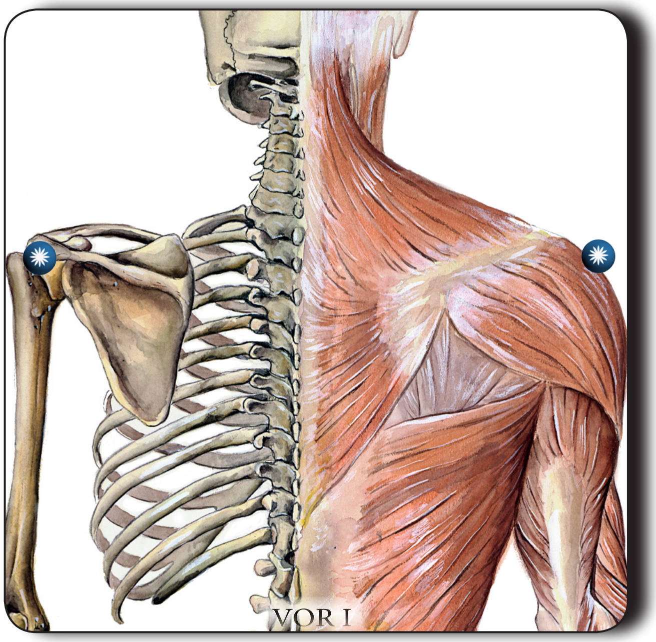
ORBICULARIS ORIS



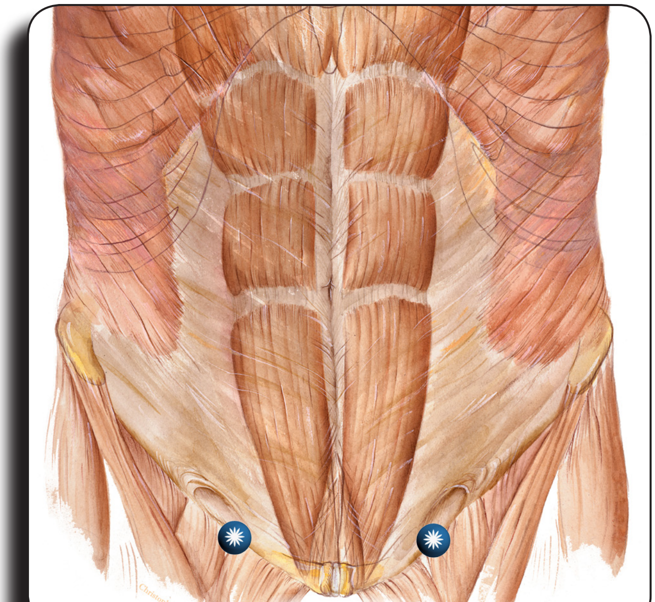
NEUROVASCULAR



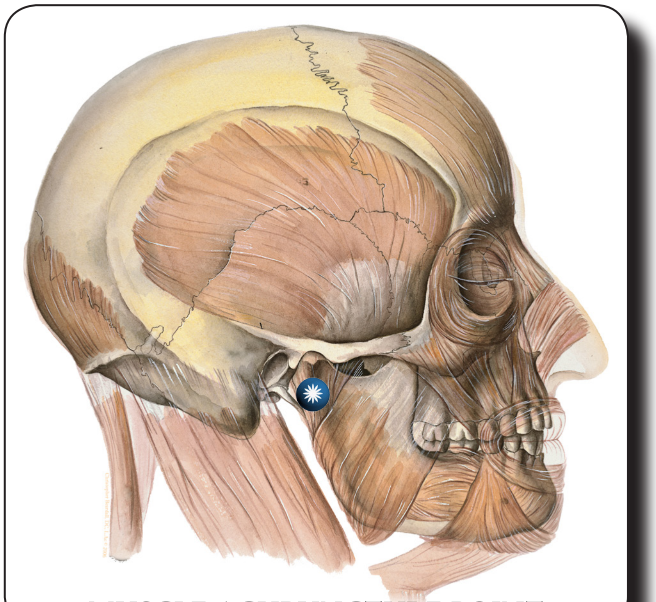
NEUROLYMPHATIC



VOR I



VOR II



MUSCLE ACUPUNCTURE POINT

Muscle 100: ORBICULARIS ORIS, (Inferior Division)

ORIGIN: Arises from many facial muscles but primarily from the mandible below and near the incisirus inferior.

INSERTION: Into itself primarily. Treatment area is half way between Cv24 and St4.

ACTION: Compression, contraction, and protrusion of lower lip.

TEST:

Hold upper lip apart with your fingers. Contract bottom lip (kiss position). Test intact muscle before and after. Note change.

NEUROVASCULAR: (Sup/BL) 1" anterior and 1/2" lateral to anterior fontanel.

NEUROLYMPHATIC: (Ant/L) 2nd ICS, 1" lateral to sternum.

VISCERAL ORGAN:

I. Anterior Pituitary: (Post/BL) inferior on lateral aspect of spine of scapula near the junction of the clavicle.

II. Gonads: (Ant/BL) Inguinal ligament 2" lateral to the origin of the 1st section of the Rectus Abdominus.

M. A. P. : G2

V.L. : T1L

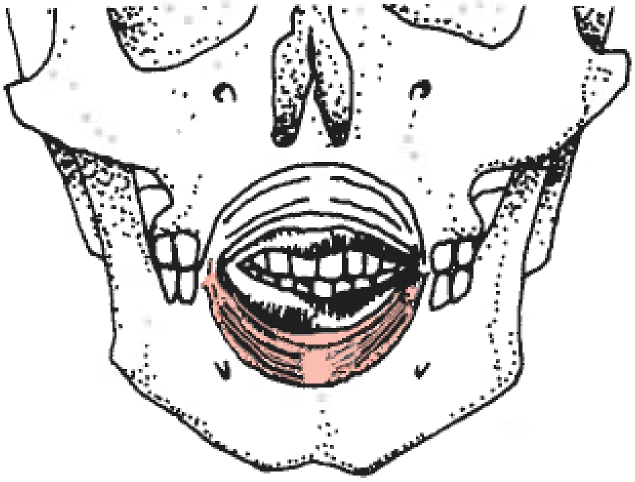
L. B. V.L. : T10L

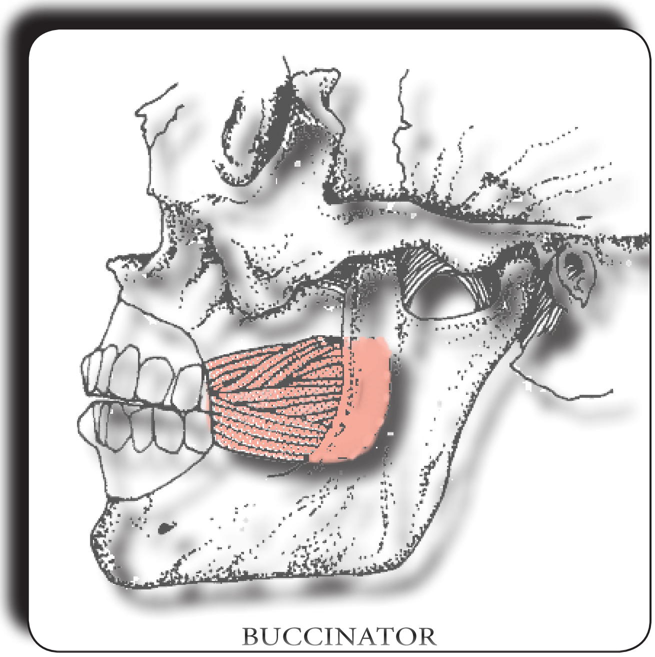
M. M. : CN VII

CRANIAL: Sphenoid

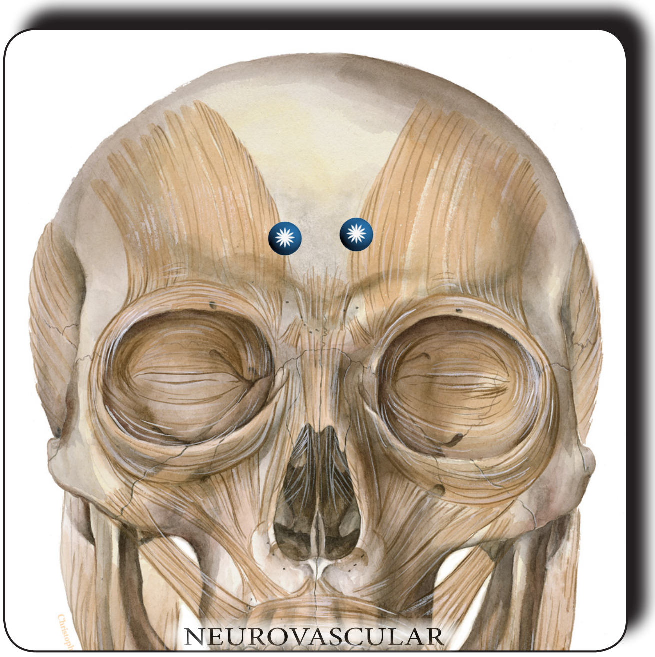
FOOT: 3rd Cunieform

NUTRIENT SOURCE: Unsaturated Fatty Acids
1. F-complex (NW)
2. Chlorophyll Plus (NW)
3. Chloroplex (NW)

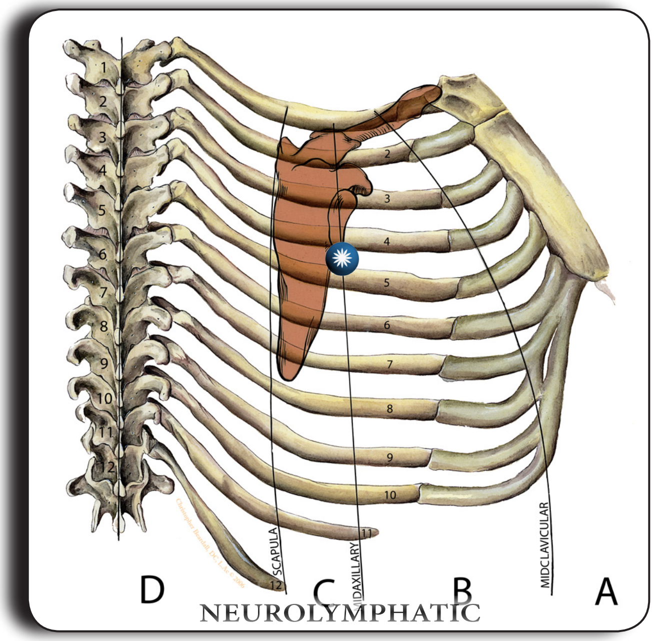




BUCCINATOR



NEUROVASCULAR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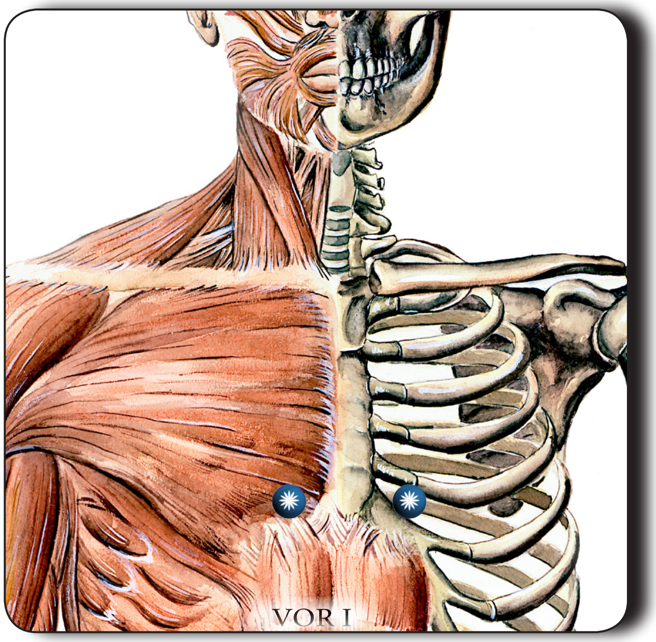
SCAPULA
MIDAXILLARY
MIDCLAVICULAR
D
C
B
A

NEUROLYMPHATIC



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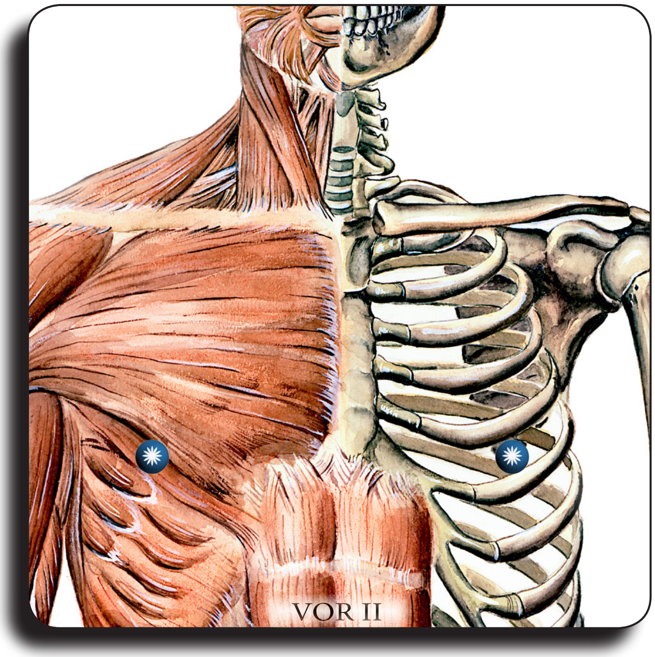

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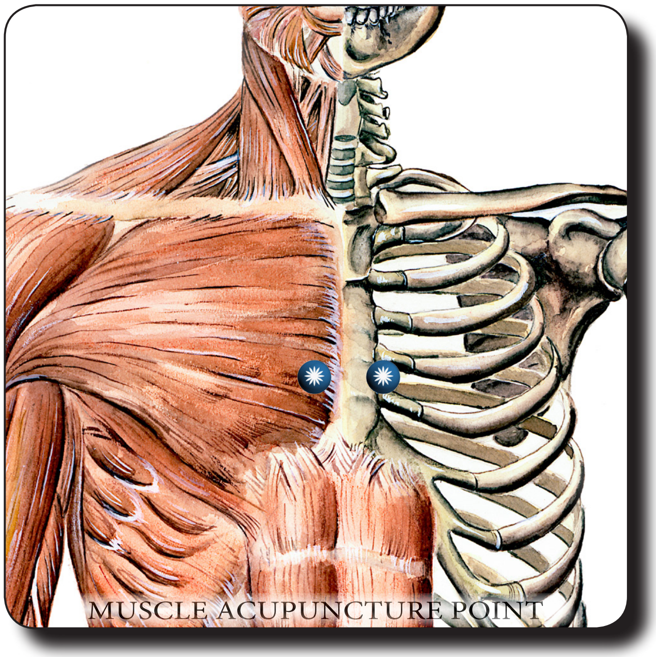


MUSCLE ACUPUNCTURE POINT

Muscle 102: BUCCINATOR

ORIGIN: Alveolar process of maxilla and mandible opposite sockets of molar teeth; anterior border of pterygo-mandibular raphé.

INSERTION: Blends with the deeper stratum of muscle fibers in the corresponding lips.

ACTION: Compresses cheek, expels air between lips, aids in mastication.

TEST:

Open jaw 1" TL between 1st molars. Have patient blow with lips contracted and buccinator relaxed. Then contract. Muscle should be able to compress air out between lips.

NEUROVASCULAR: (Ant/BL) Frontal bone, 1" superior and 1/2" lateral to Nasion.

NEUROLYMPHATIC: (Lat/R) 3rd ICS mid-axillary line.

VISCERAL ORGAN:

I. *Gonads:* (Ant/BL) K22 bilateral 5th ICS, 1" lateral to the costosternal junction.

II. *Transverse Colon - Veins:* (Ant/BL) 5th ICS, midclavicular line.

M. A. P. : Li19

V.L. : T9L

L. B. V.L. : T2L

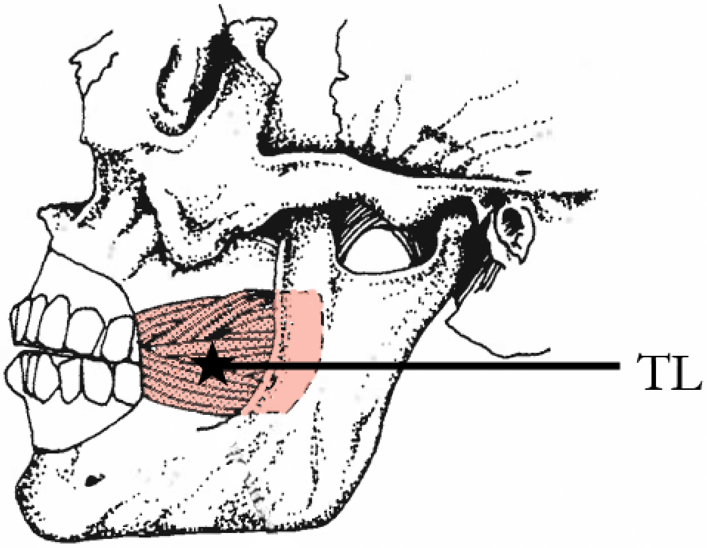
M. M. : CN VII

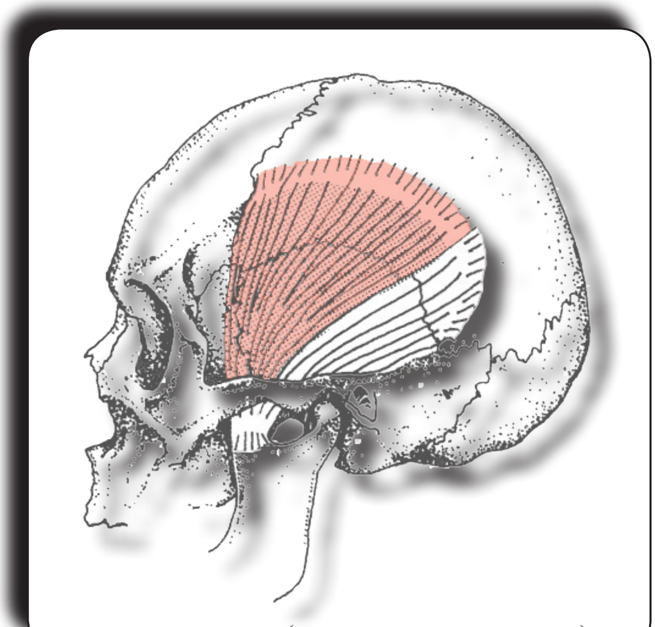
CRANIAL: Frontal

FOOT: Navicular

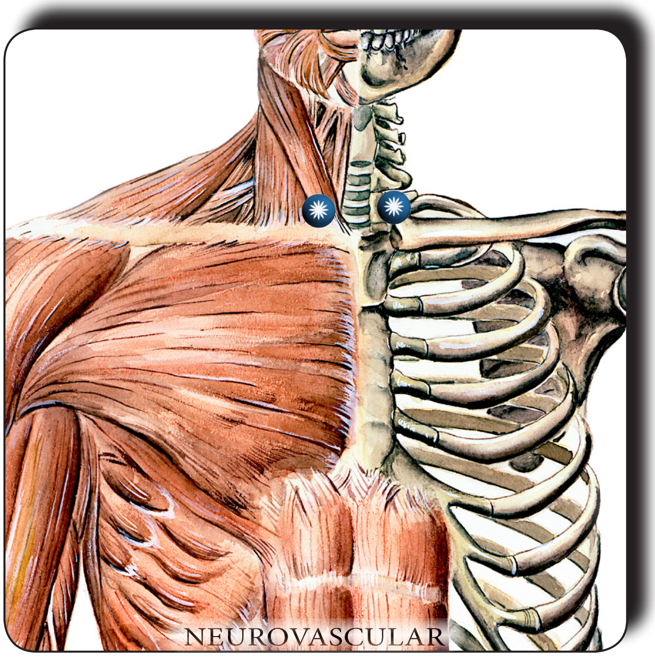
NUTRIENT SOURCE: B12

1. Core Health Reserve (NW)
2. B-Complex (NW)
3. B12 Lozenge (NW)





TEMPORALIS (PARIETAL DIVISION)



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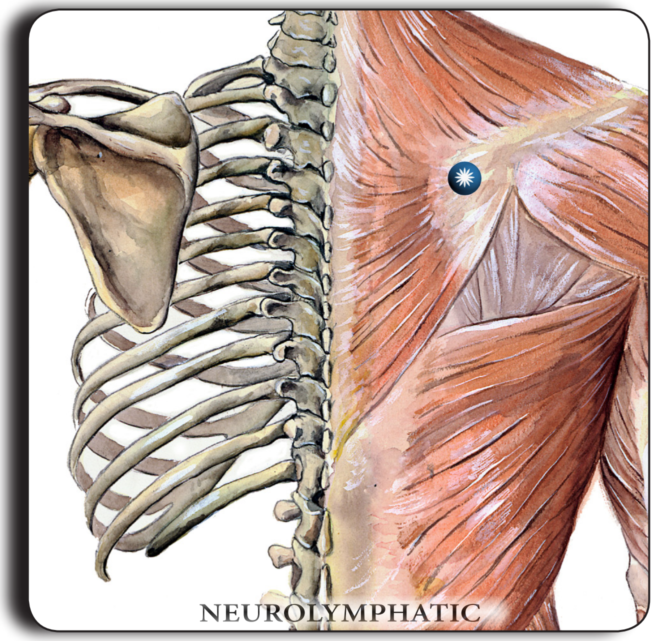

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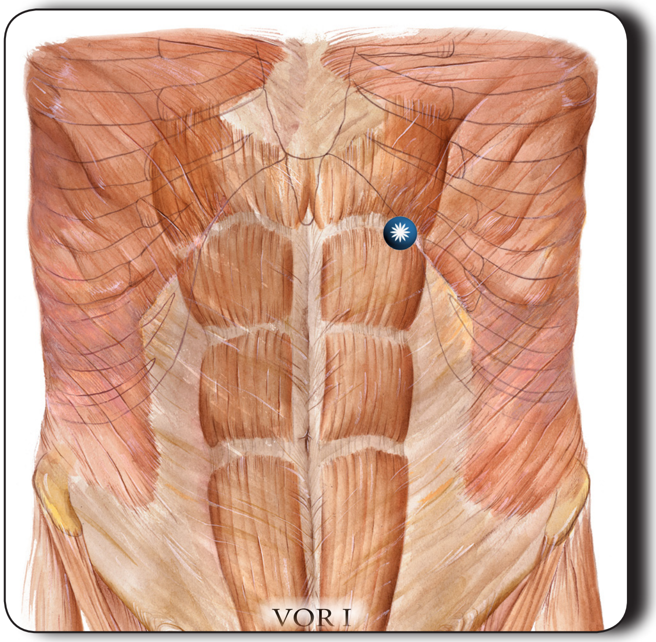

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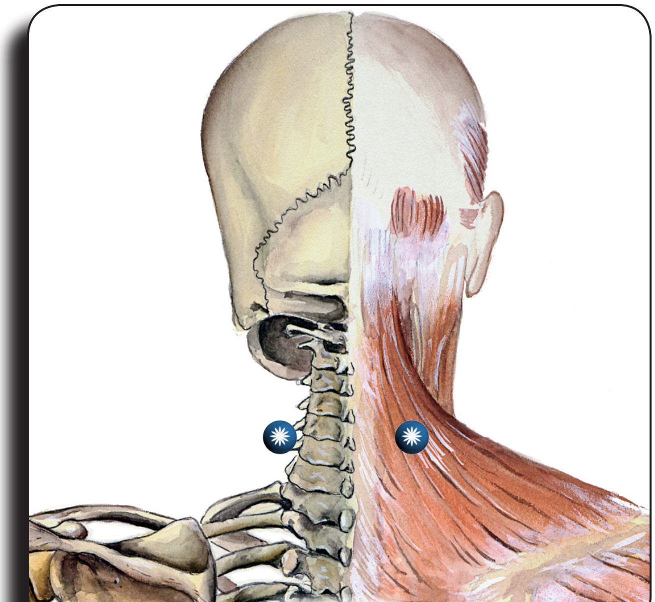
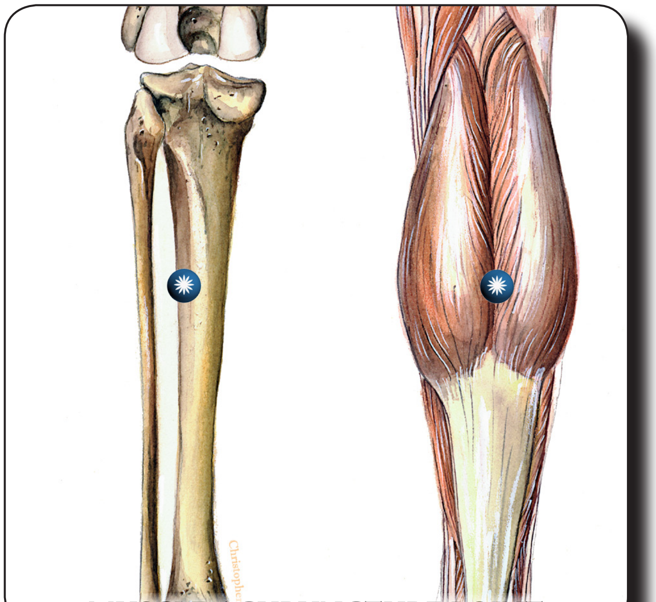


VOR II



MUSCLE ACUPUNCTURE POINT

Muscle 110: TEMPORALIS, (Parietal Division)

ORIGIN: Temporal fossa, anterior to a line perpendicular to the ear.

INSERTION: Medial surface, apex and anterior border of coronoid process of mandible.

ACTION: Elevates jaw, retracts mandible, clenches teeth.

TEST:

TL challenge: TL the temporalis muscle just superior to anterior aspect of the zygomatic arch.

Muscle challenge: Open jaw completely. Test intact muscle.

NEUROVASCULAR: (Ant/BL) Superior-medial surface of clavicle just before sternum.

NEUROLYMPHATIC: (Post/R) 3rd ICS, at vertebral border of scapula.

VISCERAL ORGAN:

I. Pancreas - Sugar: (Ant/L) St19.

II. Pharynx: (Post/BL) Level of C5 in belly of Upper Trapezius.

M. A. P. : B56.2

V.L. : T5L

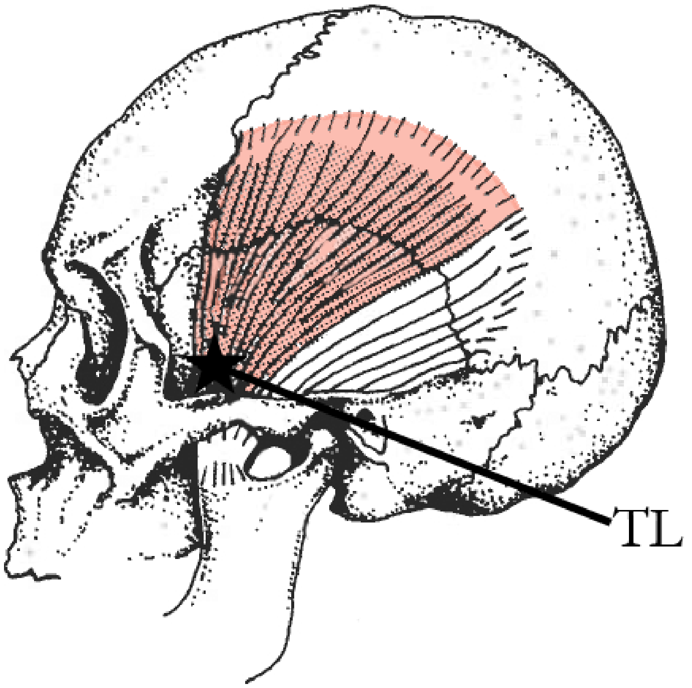
L. B. V.L. : T6L

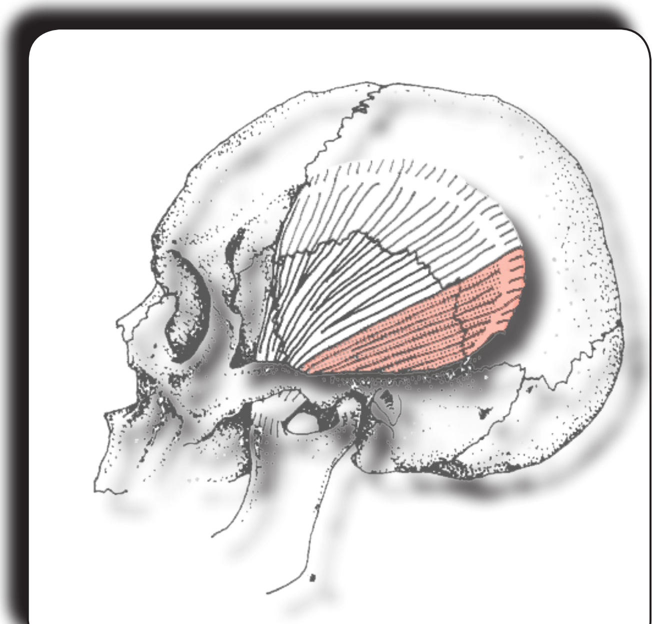
M. M. : CN V

CRANIAL: Parietal

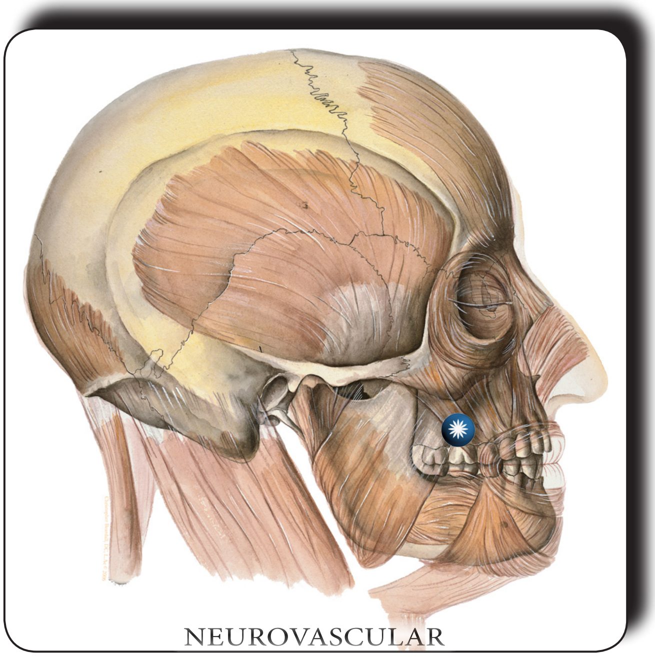
FOOT: Talus

NUTRIENT SOURCE: Niacin
1. Core Niacin (NW)
2. Core B6 (NW)
3. Niacin B-6 (NW)

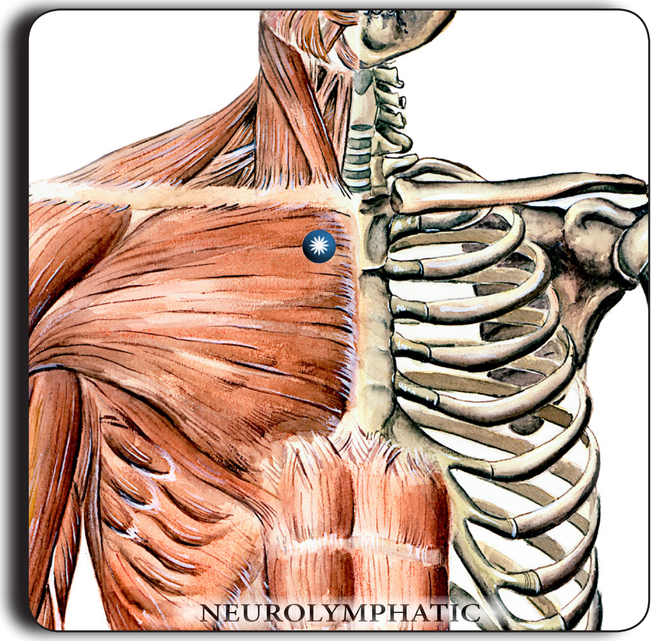




TEMPORALIS (OCCIPITAL DIVISION)



NEUROVASCULAR



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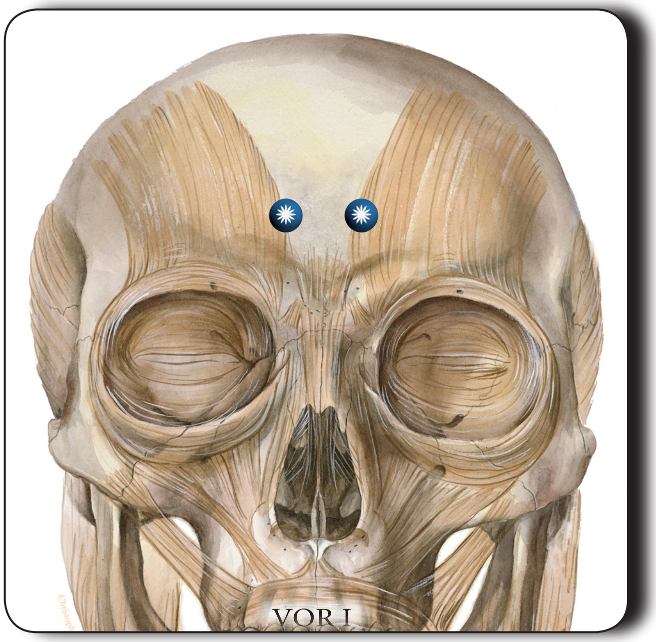

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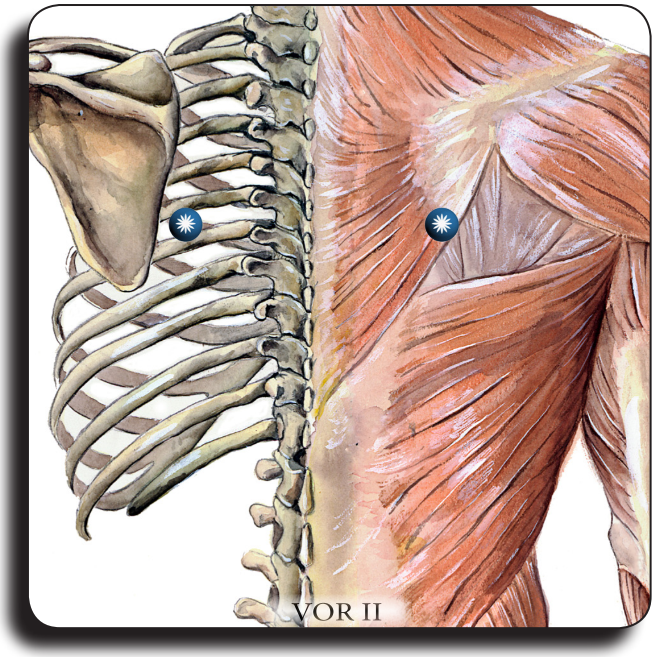

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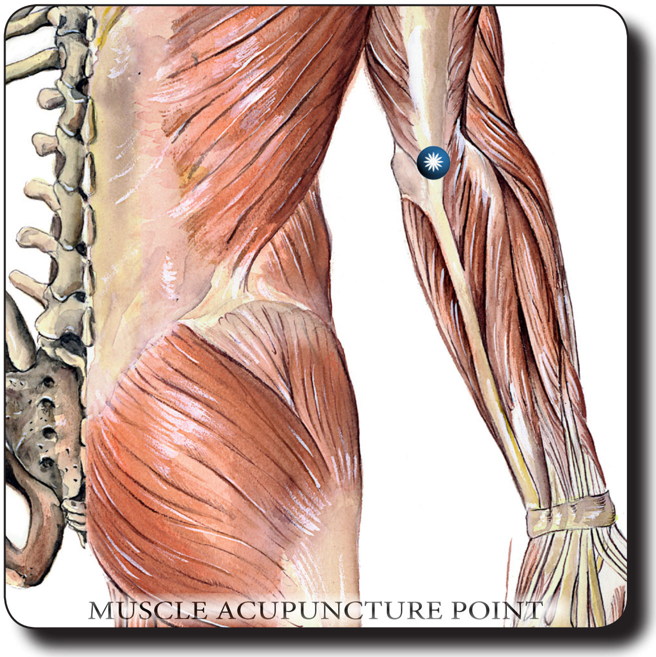


MUSCLE ACUPUNCTURE POINT

Muscle 112: TEMPORALIS, (Occipital Division)

ORIGIN: Temporal fossa, posterior to a line perpendicular to the ear.

INSERTION: Apex and anterior border of coronoid process of mandible.

ACTION: Elevates jaw, retracts mandible, clenches teeth.

TEST:

TL challenge: TL the temporalis muscle just superior to the posterior aspect of the zygomatic arch.

Muscle challenge: Open jaw 1/2"-3/4", then retract it. Test intact muscle.

NEUROVASCULAR: (Lat) Maxillary bone, directly superior to 1st molar.

NEUROLYMPHATIC: (Ant/R) 1st ICS at sternum.

VISCERAL ORGAN:

I. Pineal: (Ant/BL) Slightly superior and lateral to Gv24.6 (near glabella).

II. Pancreatic Duct System: (Post/BL) Vertebral border of the scapula at level of B39 and 6th rib.

M. A. P. : Tw10

V.L. : L3R

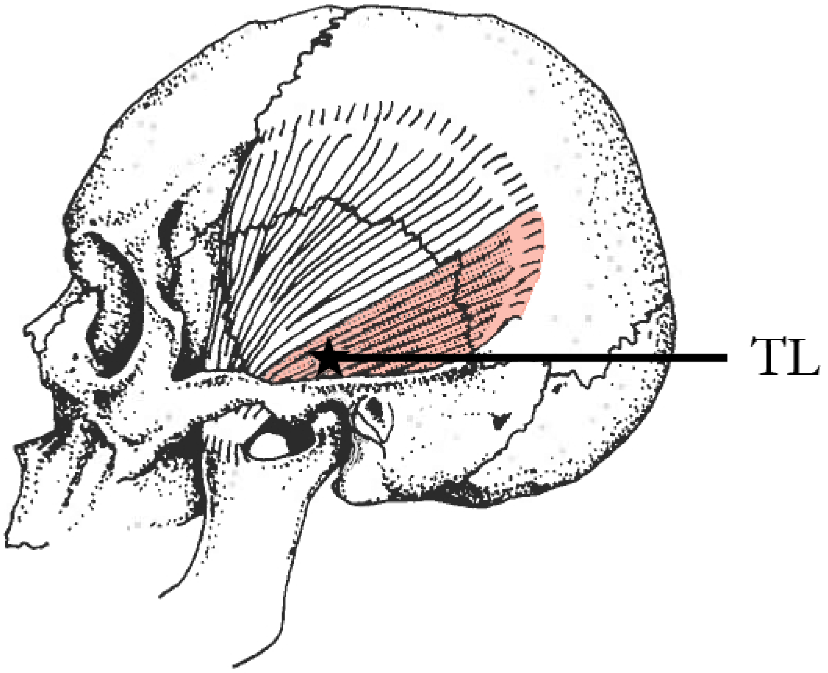
L. B. V.L. : C3R

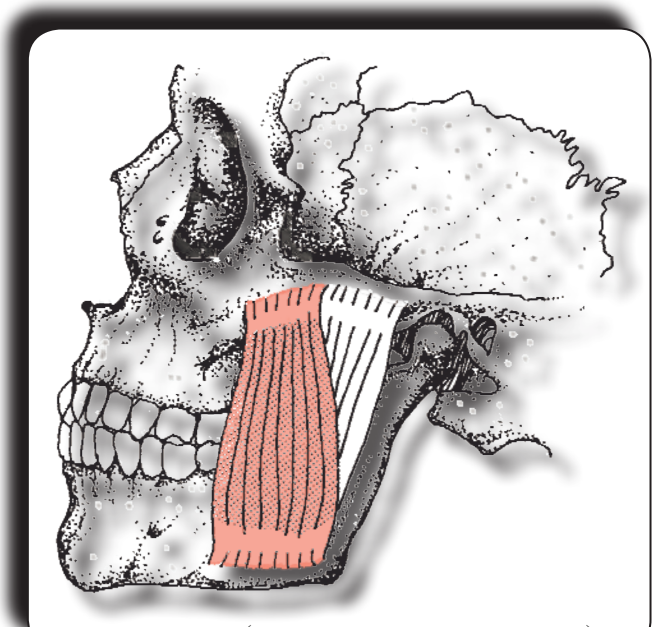
M. M. : CN V

CRANIAL: Vomer

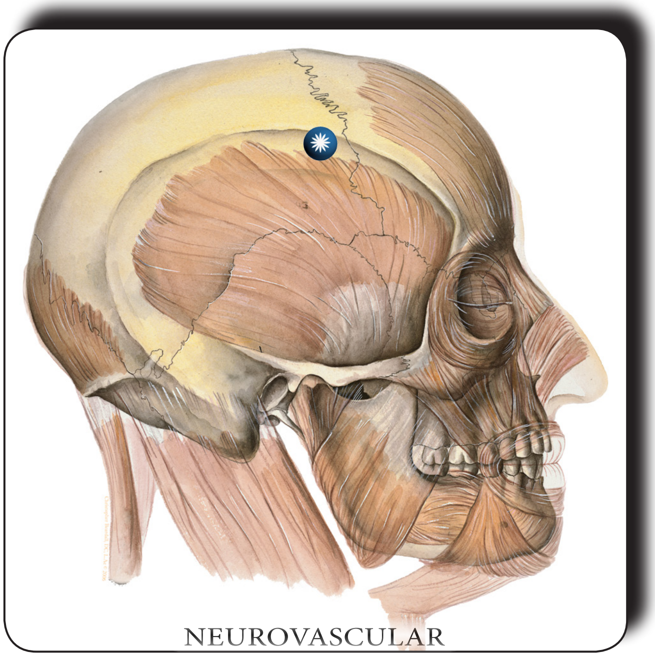
FOOT: 2nd Metatarsal

NUTRIENT SOURCE: Phosphorus
1. Phos-drops

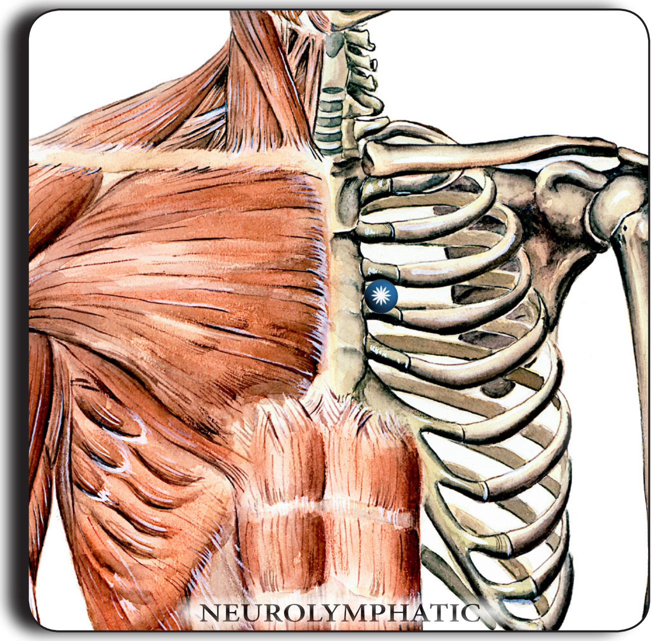




MASSETER (SUPERFICIAL DIVISION)



NEUROVASCULAR



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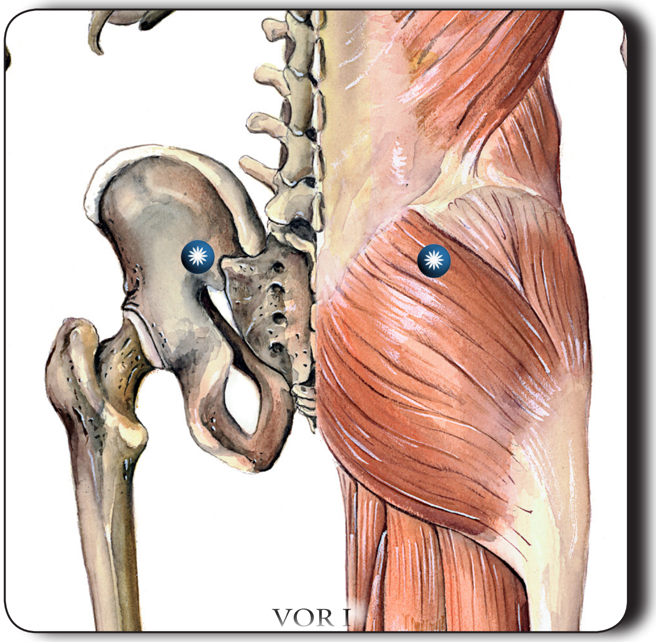

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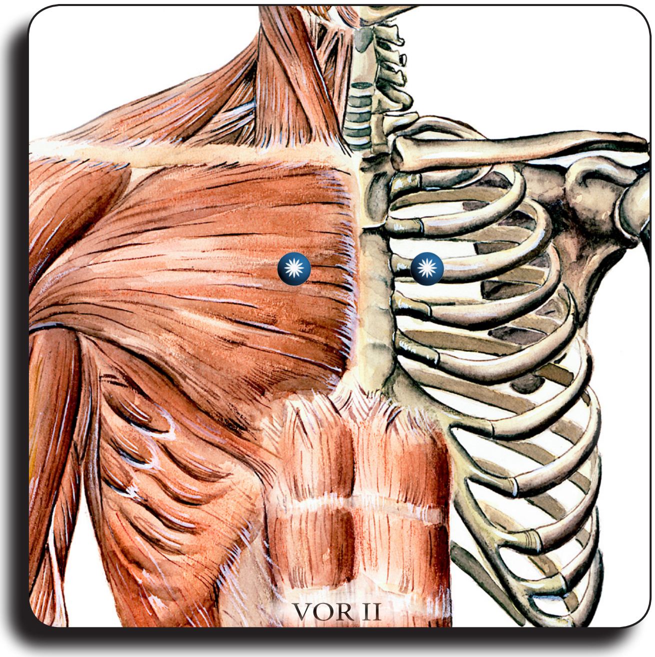

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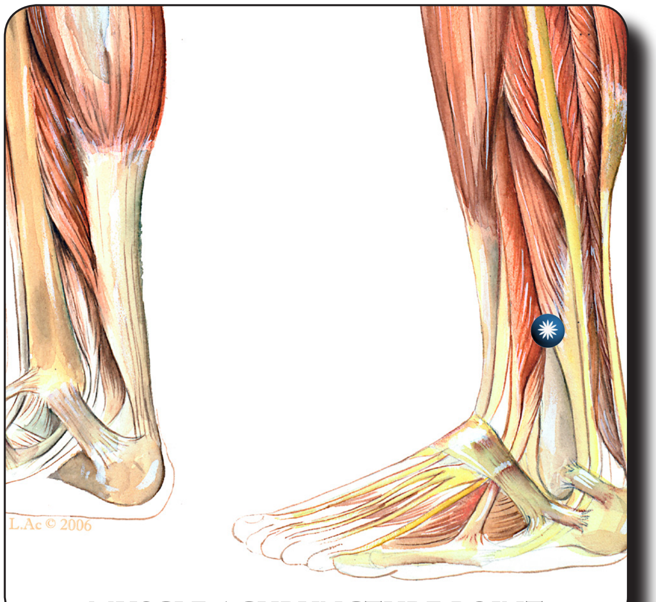


MUSCLE ACUPUNCTURE POINT

Muscle 114: MASSETER, (Superficial Division)

ORIGIN: Zygomatic process of maxillary bone.

INSERTION: Angle and lower half of lateral surface of ramus of the mandible. Muscle inserts anterior to angle of jaw.

ACTION: Elevates jaw, clenches teeth.

TEST:

TL challenge: TL the lateral aspect of the jaw, 1" anterior to the angle.

Muscle challenge: Protrude jaw as far as possible, then occlude jaw (bite). Test intact muscle.

NEUROVASCULAR: (Lat) Parietal bone, 1" posterior to coronal suture on the superior temporal line.

NEUROLYMPHATIC: (Ant/L) 3rd ICS, at sternum.

VISCERAL ORGAN:

I. *Adrenals:* (Post/BL) 1" lateral to PSIS in the Gluteus Maximus, Iliac Division.

II. *Lungs/Bronchioles:* (Ant/BL) 3rd costocartilage junction, superior aspect.

M. A. P. : G38.5

V.L. : L3R

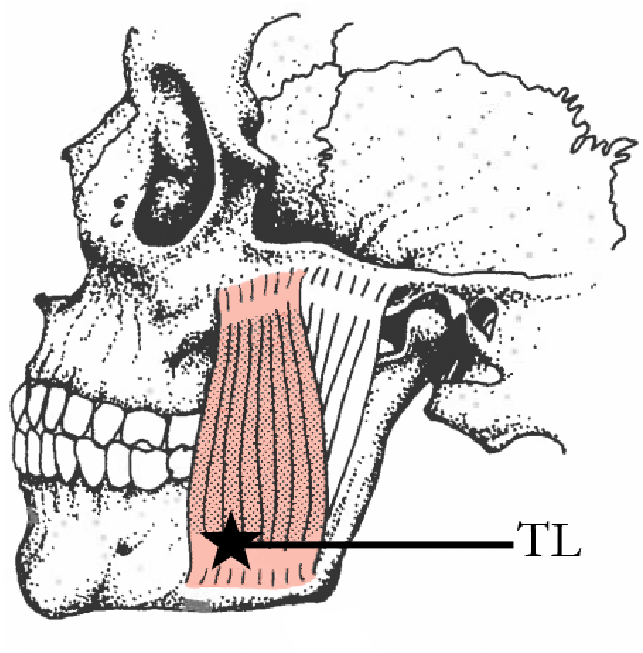
L. B. V.L. : C3R

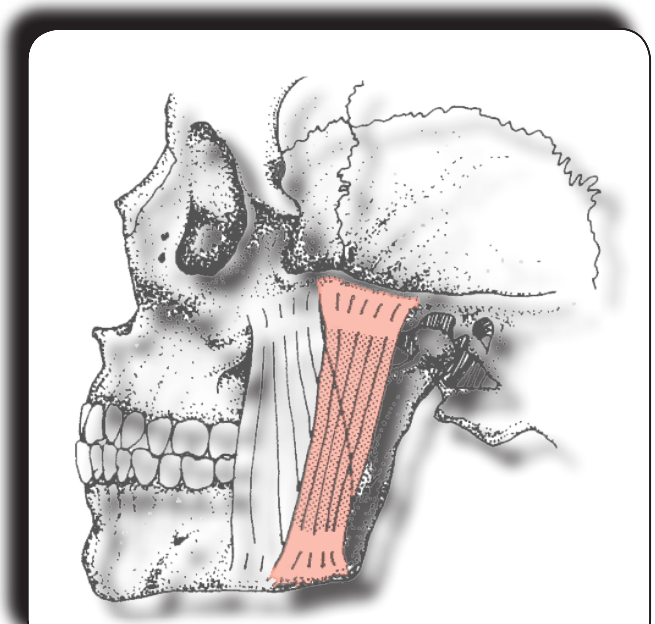
M. M. : CN V

CRANIAL: Mandible

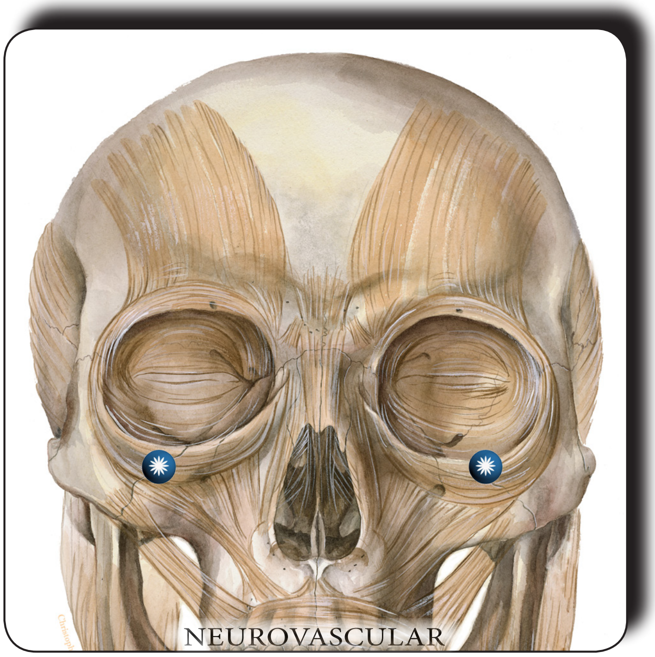
FOOT: Proximal phalanx-great toe

NUTRIENT SOURCE: Adrenal Concentrate
1. Core Adrenal (NW)

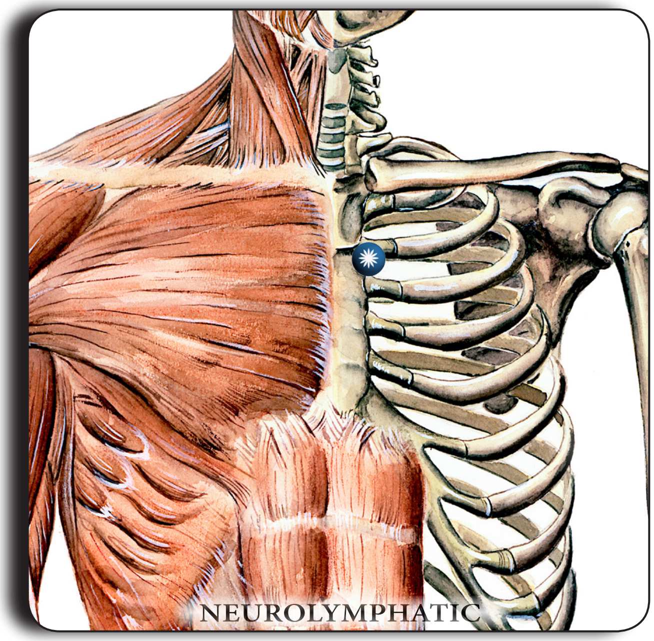




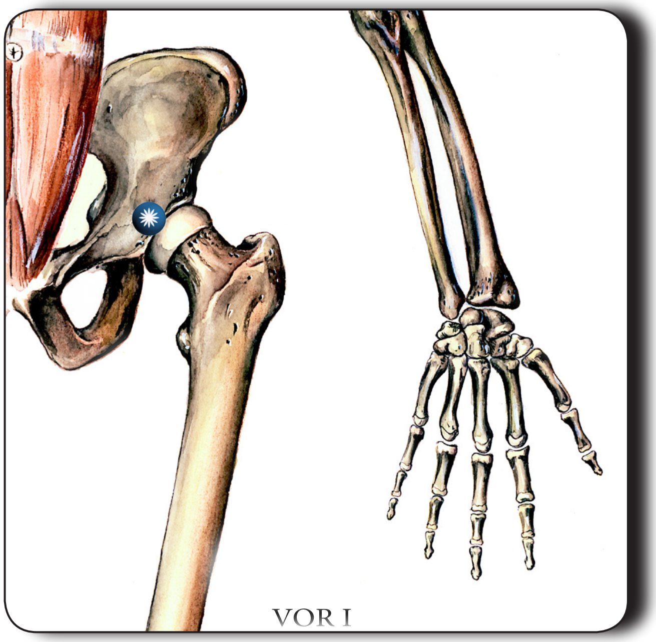
MASSETER, (DEEP DIVISION)



NEUROVASCULAR



NEUROLYMPHATIC



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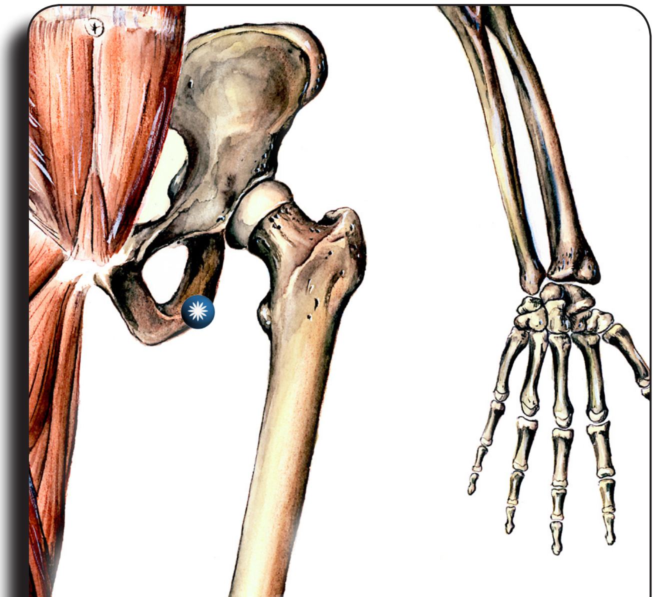

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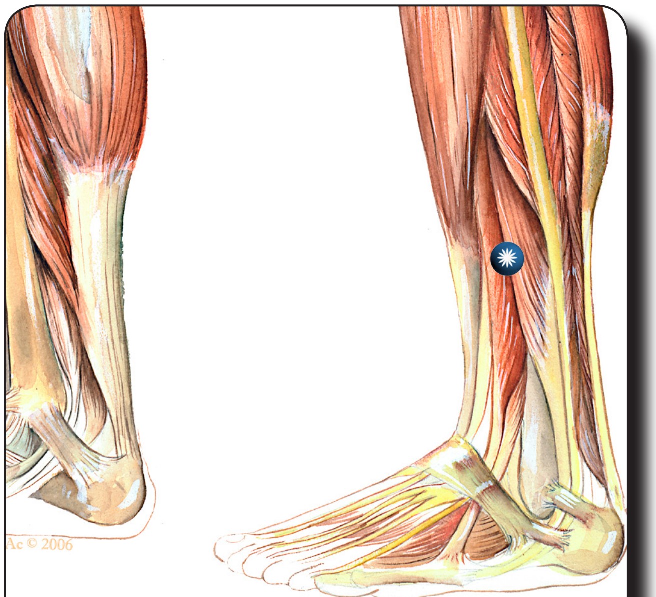


MUSCLE ACUPUNCTURE POINT

Muscle 118: MASSETER,
(Deep Division)

ORIGIN: Zygomatic arch of temporal bone.

INSERTION: Upper half of ramus and lateral surface of coronoid process of mandible. Inserts posterior to the superficial division.

ACTION: Elevates jaw, clenches teeth.

TEST:

TL challenge: TL the lateral aspect of the jaw 1" superior to the angle.

Muscle challenge: Close jaw with pressure on molars. Test intact muscle.

NEUROVASCULAR: (Ant/BL) Maxillary bone, inferior to eye orbit near maxillary-zygomatic suture.

NEUROLYMPHATIC: (Ant/L) 2nd ICS, near sternum.

VISCERAL ORGAN:

I. *Posterior Pituitary:* (Ant/L) Lip of acetabulum, just lateral to Sp12

II. *Thyroid:* (Ant/L) Inferior ramus of pubes just medial to Lv10.

M. A. P. : G37.5

V.L. : L4L

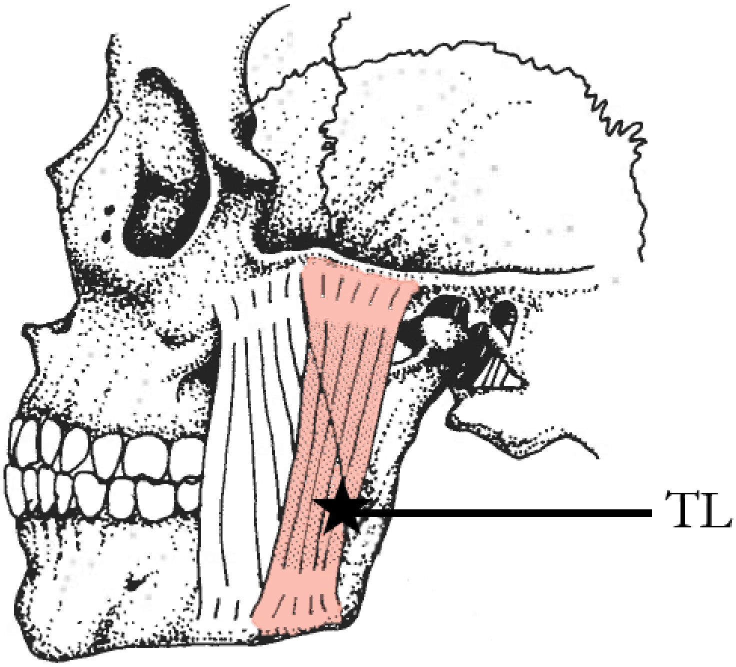
L. B. V.L. : C2L

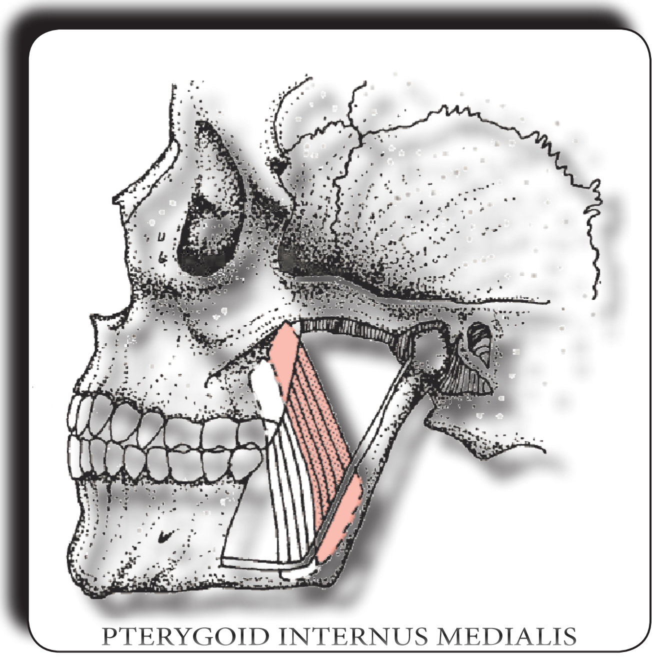
M. M. : CN V

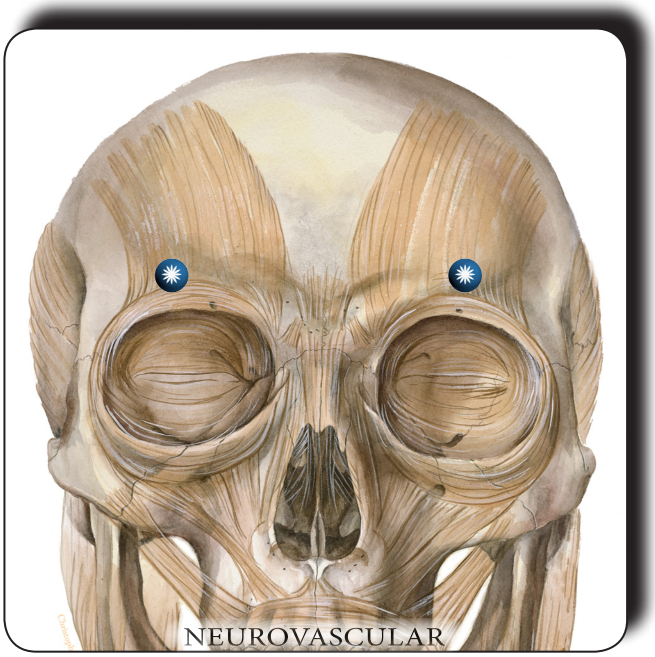
CRANIAL: Vomer

FOOT: 2nd Metatarsal

NUTRIENT SOURCE: Indium, Chaparral
1. Core Health Reserve




PTERYGOID INTERNUS MEDIALIS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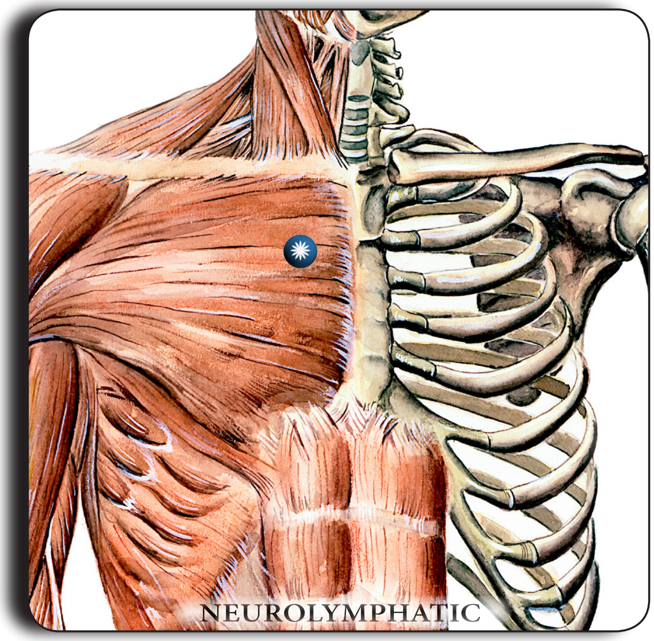
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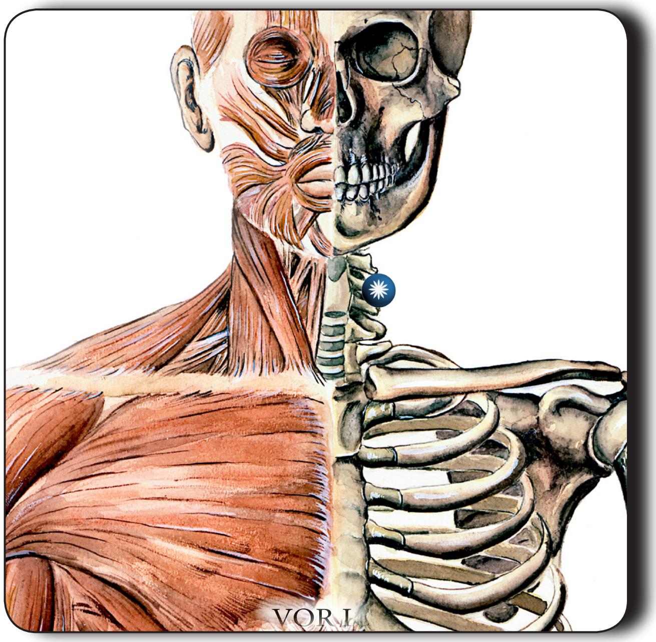
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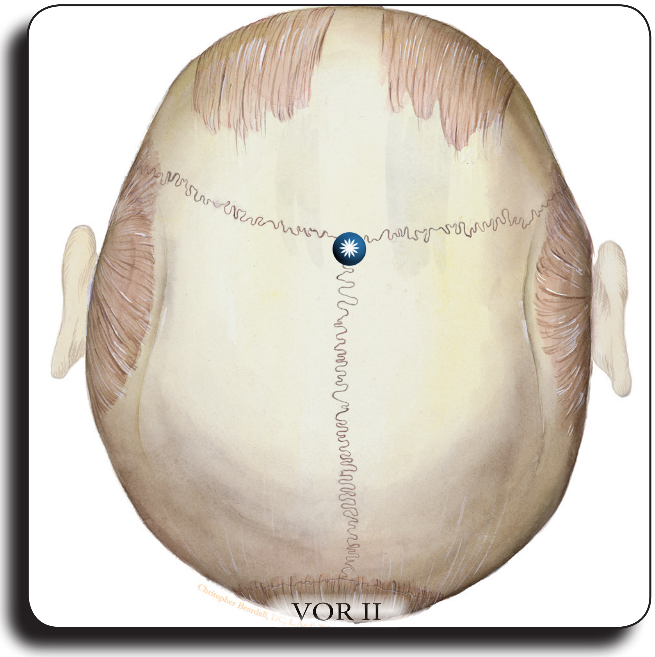
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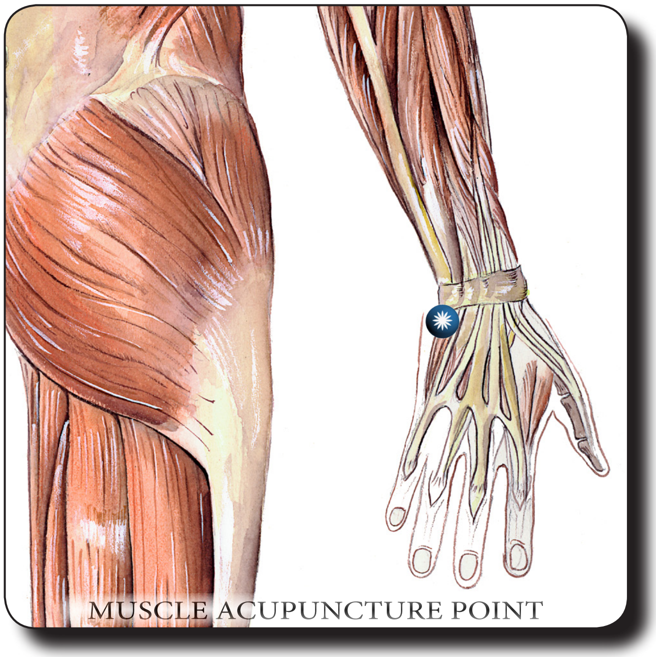

MUSCLE ACUPUNCTURE POINT

Muscle 120: PTERYGOID INTERNUS MEDIALIS, (Sphenoid Division)

ORIGIN: Medial surface of lateral pterygoid plate of sphenoid.

INSERTION: Lower posterior aspect of medial surface of ramus and angle of mandible. Inserts posterior to the palatine division.

ACTION: Protracts and elevates lower jaw, assists in rotary motion while chewing.

TEST:

TL challenge: TL the medial aspect of the angle of the jaw.

Muscle challenge: Place incisors together and bite. Test intact muscle.

NEUROVASCULAR: (Ant/BL) Frontal bone, at inferior surface of supraciliary ridge of eye orbit at 12 o'clock.

NEUROLYMPHATIC: (Ant/R) 2nd ICS, at sternum.

VISCERAL ORGAN:

I. Thyroid: (Ant) Belly of sternohyoid near insertion below hyoid.

II. Posterior Pituitary: (Sup) Gv21, anterior fontanelle.

M. A. P. : Si5

V.L. : L5R

L. B. V.L. : C1R

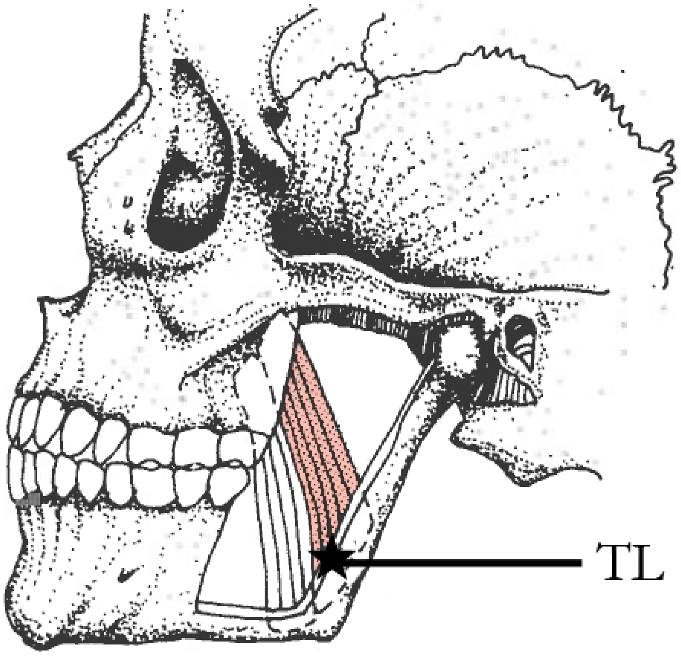
M. M. : CN V

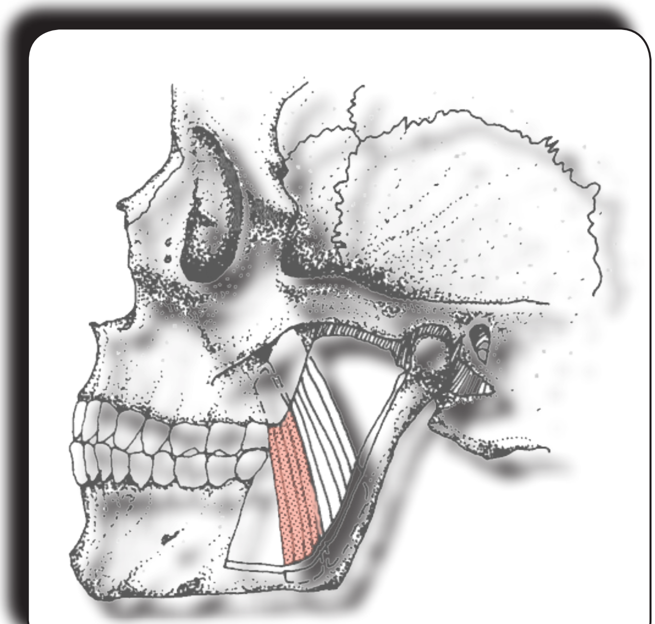
CRANIAL: Lacrimal

FOOT: Proximal phalanx 2nd toe

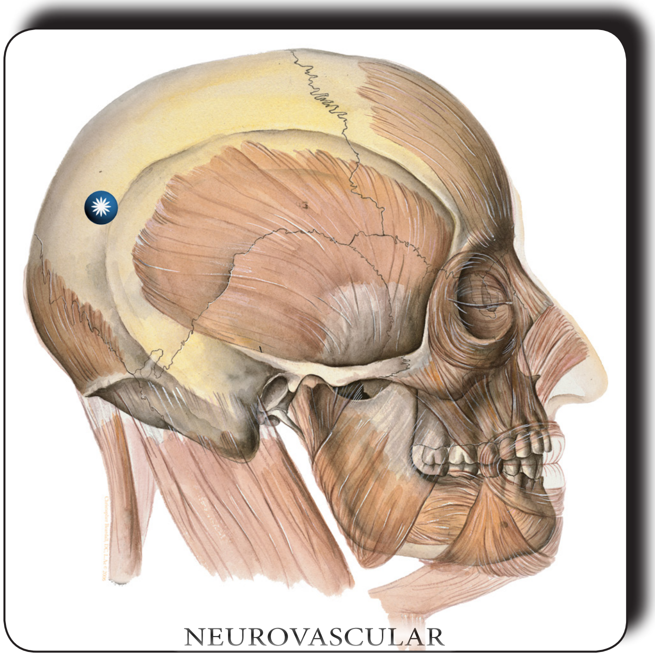
NUTRIENT SOURCE: B2 (Riboflavin)

1. Core Health Reserve (NW)
2. B-Complex (NW)
3. Core Folic Acid

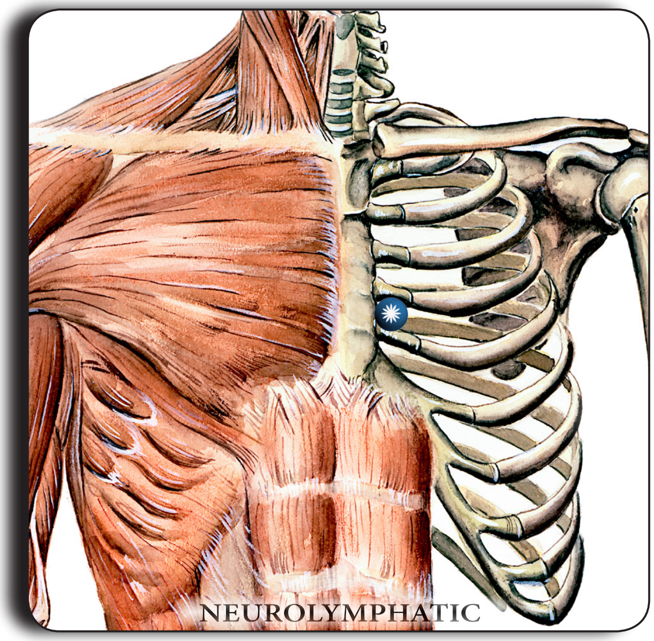




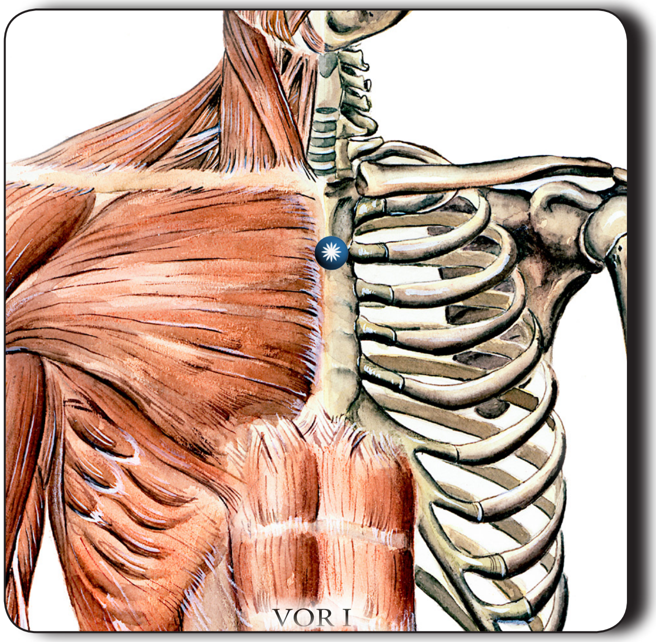
PTERYGOID INTERNUS MEDIALIS



NEUROVASCULAR



NEUROLYMPHATIC



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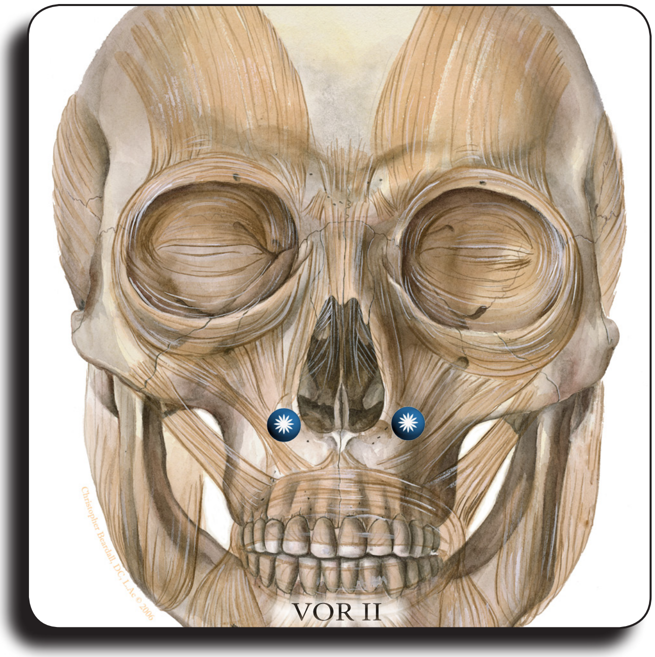

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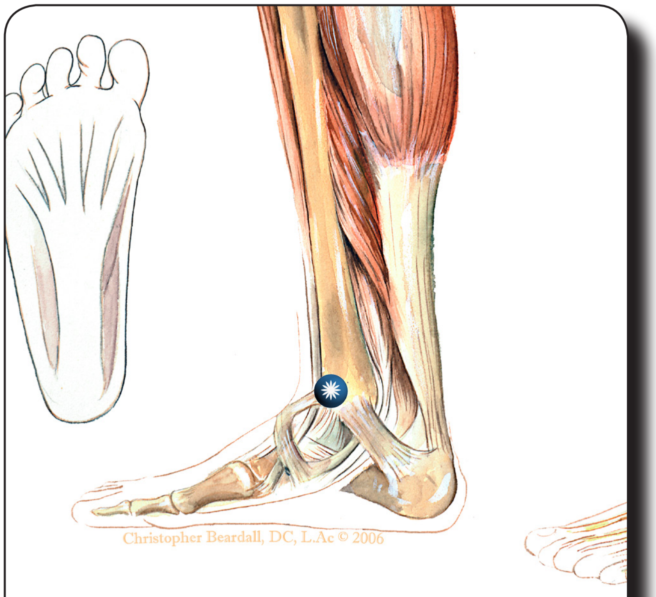

Christopher Beardall, DC, L.Ac © 2006

MUSCLE ACUPUNCTURE POINT

Muscle 122: PTERYGOID INTERNUS MEDIALIS, (Palatine Division)

ORIGIN: Pyramidal process of palatine.

INSERTION: Inferior and posterior aspect of medial side of ramus and angle of mandible.

ACTION: Protracts and elevates lower jaw; assists in rotary motion while chewing.

TEST:

TL challenge: TL the medial aspect of the jaw 1" anterior to the angle.

Muscle challenge: Occlude mandible incisors anterior to maxillary incisors, close and pull posterior. Test intact muscle.

NEUROVASCULAR: (Lat) Parietal bone, posterior aspect of parietal eminence, superior to temporal line.

NEUROLYMPHATIC: (Ant/L) 4th ICS, at sternum.

VISCERAL ORGAN:

I. Thymus: (Ant) Angle of Louis midline on sternum.

II. Tonsils: (Ant/BL) Li19, maxillary bone, lateral and inferior to nose.

M. A. P. : Lv4

V.L. : C3L

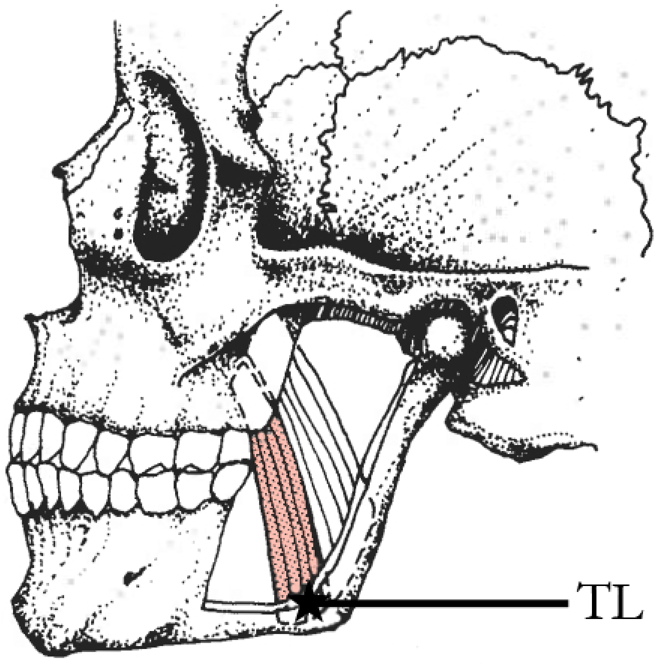
L. B. V.L. : L3L

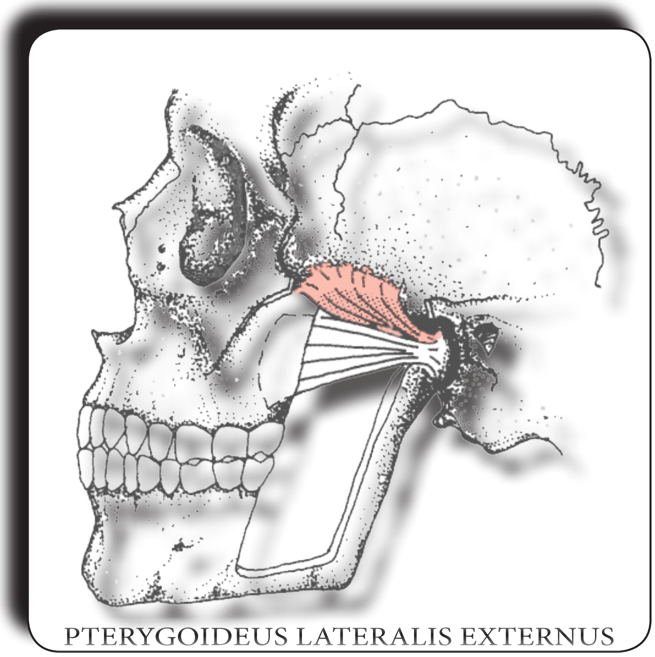
M. M. : CN V

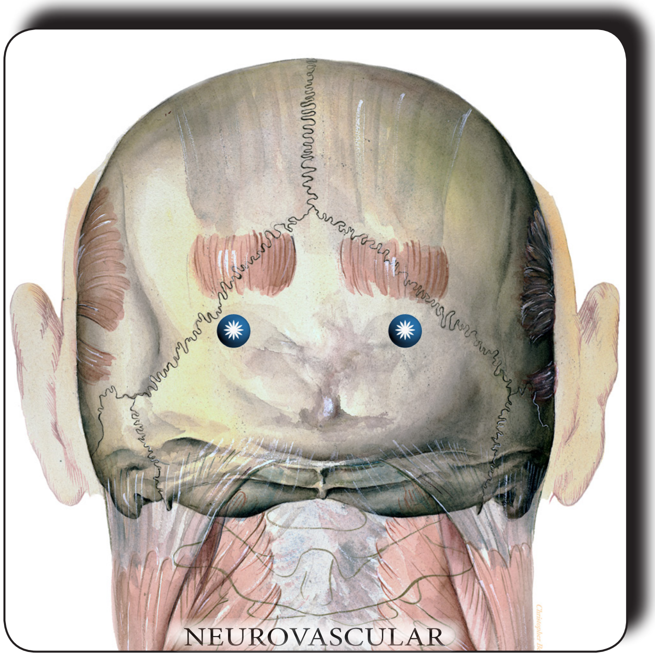
CRANIAL: Lateral Rocker

FOOT: None

NUTRIENT SOURCE: Magnesium
1. Core Magnesium (NW)
2. Core Thymus (NW)




PTERYGOIDEUS LATERALIS EXTERNUS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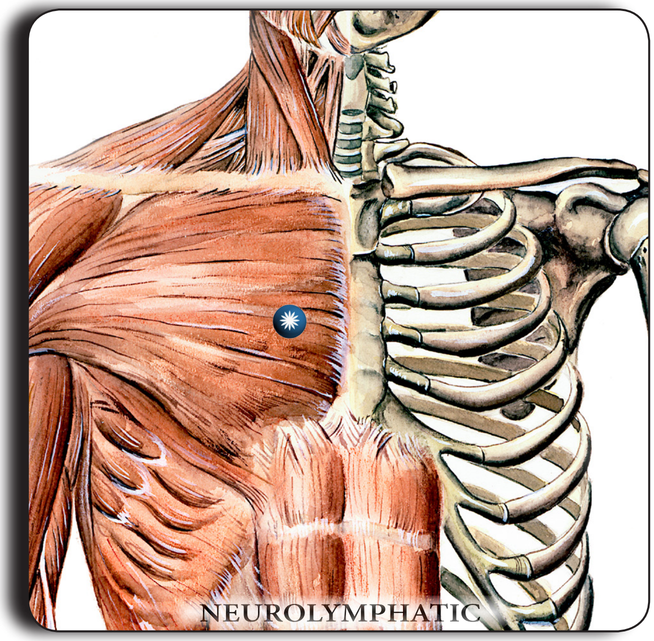
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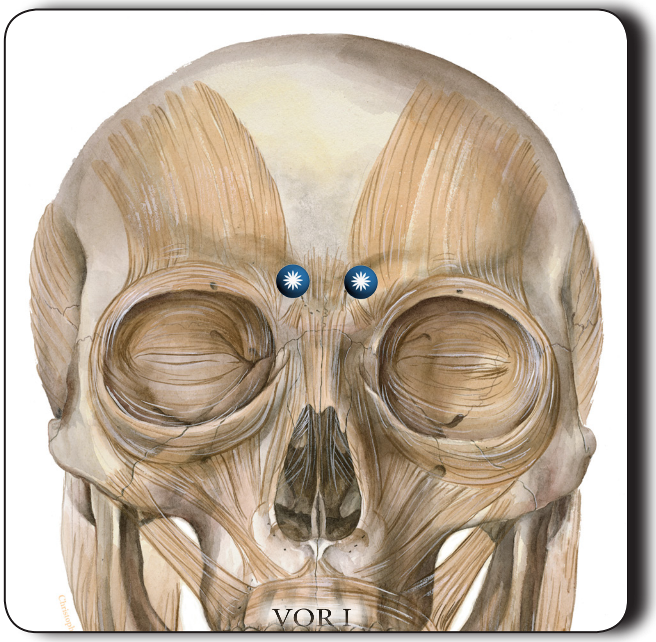
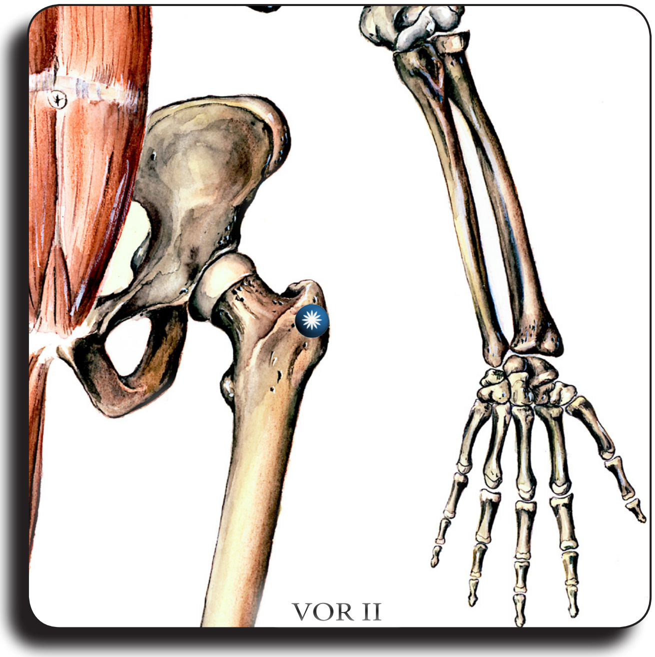

VOR I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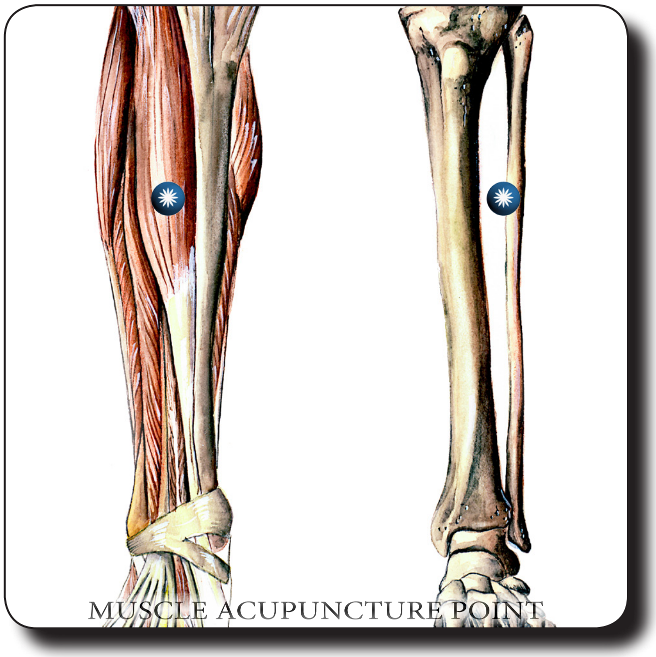

MUSCLE ACUPUNCTURE POINT

Muscle 124: PTERYGOIDEUS LATERALIS EXTERNUS, (Upper Division-disc)

ORIGIN: Inferior part of lateral surface of greater wing of sphenoid and from the infratemporal crest.

INSERTION: A depression in front of neck of condyle of mandible and into front margin of articular disc of TMJ.

ACTION: Protrudes mandible, pulls articular disc forward; assists lateral motion.

TEST:

TL challenge: TL upper anterior aspect of condyle.

Muscle challenge: Open jaw 1-2", protrude and move lateral as far as possible. Test intact muscle.

NEUROVASCULAR: (Post/BL) Occipital bone, inferior to lambdoidal suture.

NEUROLYMPHATIC: (Ant/R) 3rd ICS, at sternum.

VISCERAL ORGAN:

I. Pineal: (Ant/BL) B2 (on superior aspect of eye orbit).

II. Testicles/Ovaries: (Ant/BL) Just superior to insertion of Gluteus Medius, anterior division.

M. A. P. : St38

V.L. : L4R

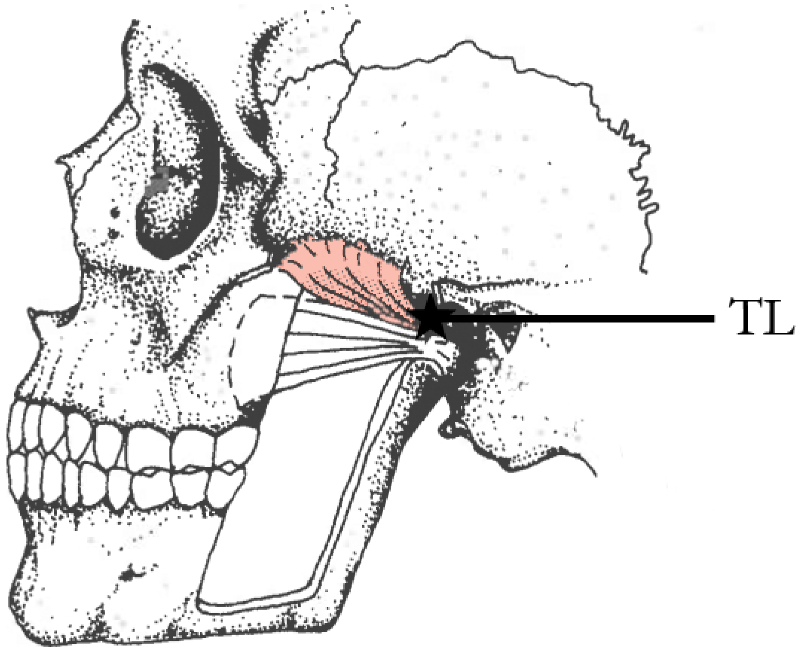
L. B. V.L. : C2R

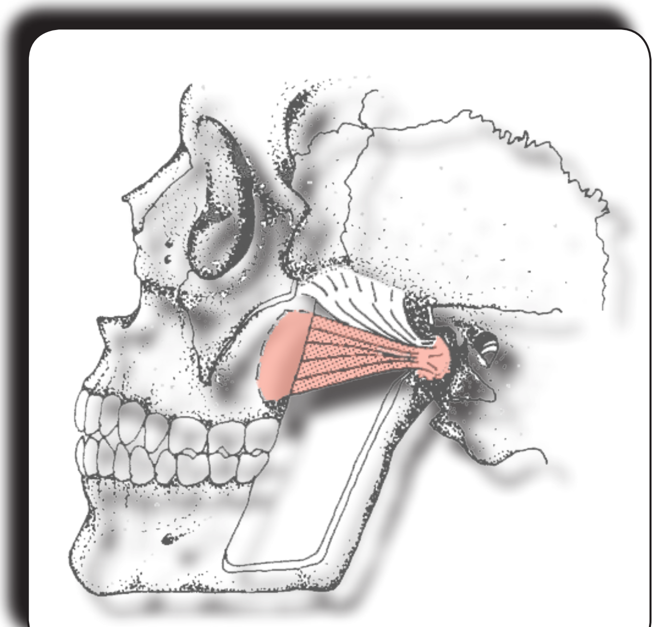
M. M. : CN V

CRANIAL: Rotation Rocker

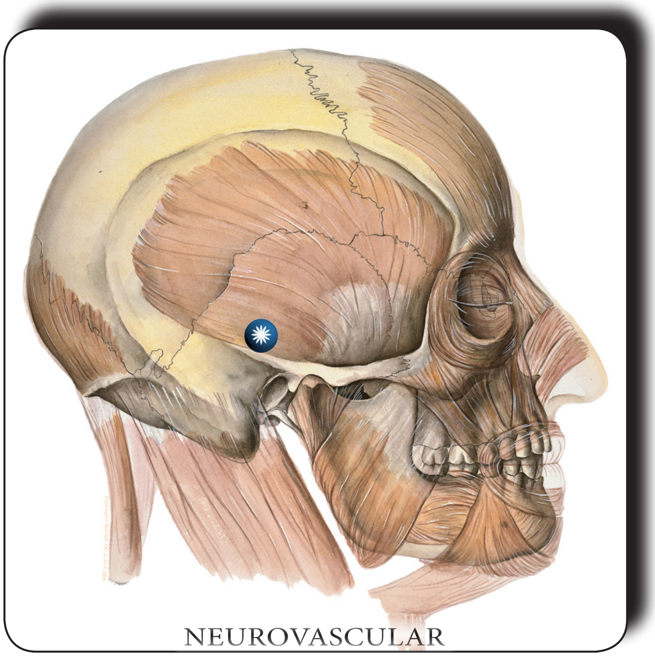
FOOT: In Research

NUTRIENT SOURCE: Thallium
1. Core Level Health Reserve
2. Amino All (NW)





PTERYGOIDEUS LATERALIS EXTERNUS



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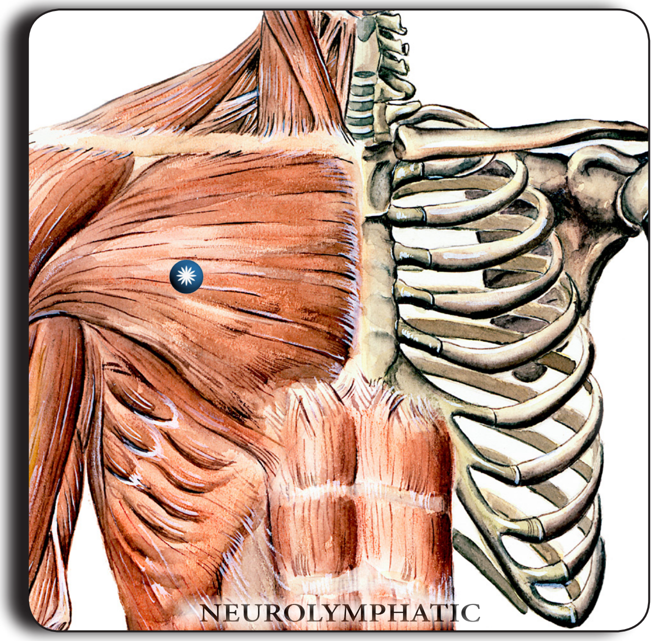

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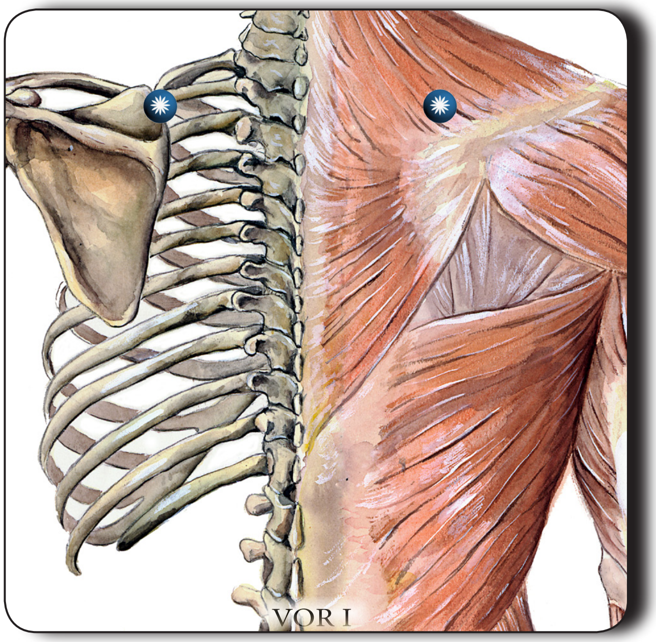

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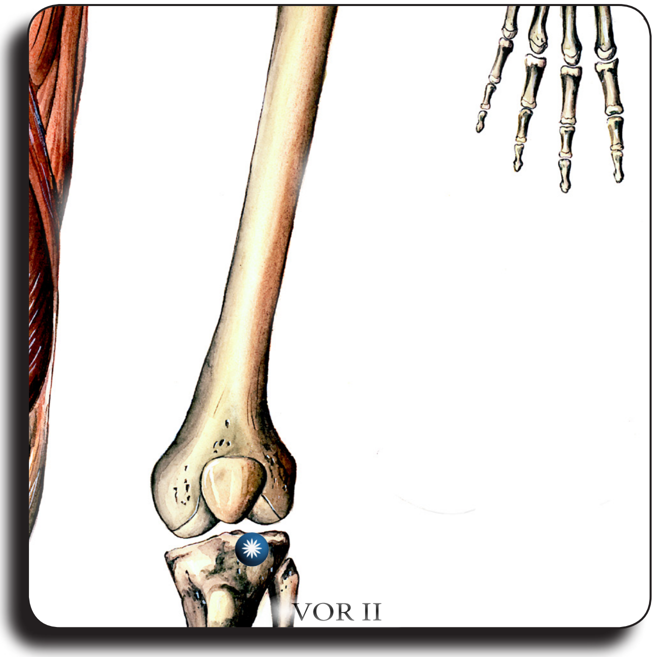

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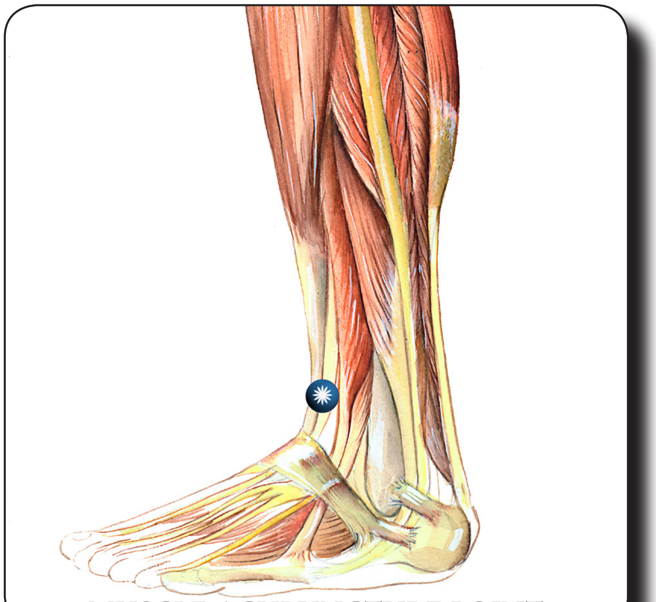


MUSCLE ACUPUNCTURE POINT

Muscle 126: PTERYGOIDEUS LATERALIS EXTERNUS, (Lower Division)

ORIGIN: Lateral surface of the lateral pterygoid plate (anterior to Masseter just under arch).

INSERTION: A depression in front of the neck of the condyle of the mandible.

ACTION: Protrudes mandible, assists in lateral motion.

TEST:

TL challenge: TL lower anterior aspects of condyle on side involved.

Muscle challenge: With mouth 1/4-1/2" open, protrude jaw and move lateral as far as possible.

NEUROVASCULAR: (Lat) Temporal bone, 1" superior to external auditory canal (EAC).

NEUROLYMPHATIC: (Ant/R) 3rd ICS, 3" lateral to sternum.

VISCERAL ORGAN:

I. Testicles/Ovaries: (Ant/BL) Scapula (origin Supraspinatus, level of 2nd rib.

II. Parathyroid: (Ant) Patella tendon, lateral insertion.

M. A. P. : St40.8

V.L. : L1L

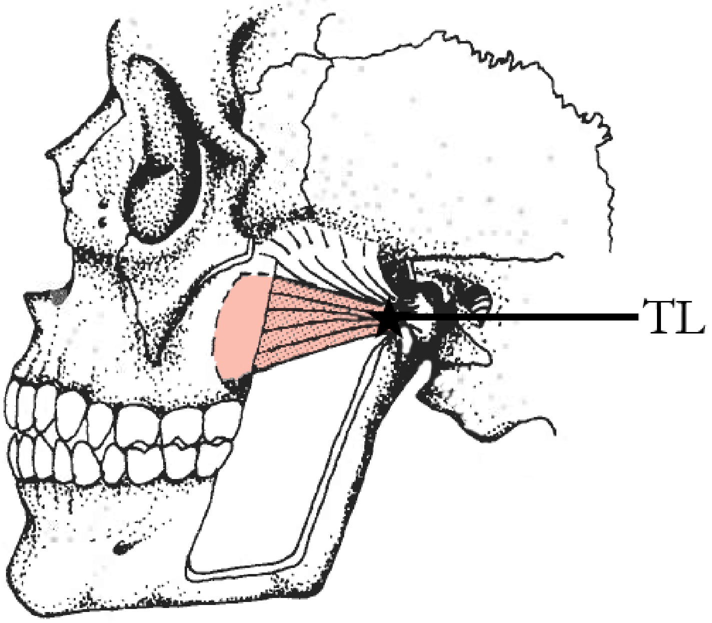
L. B. V.L. : C5L

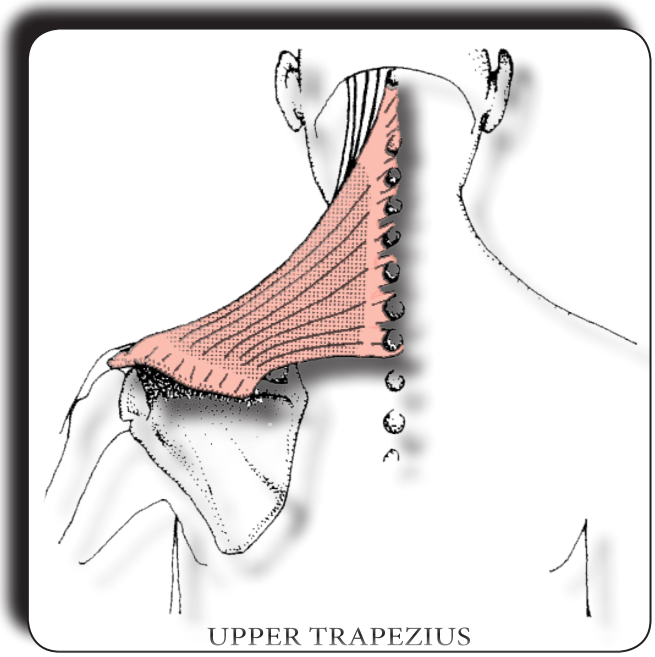
M. M. : CN V

CRANIAL: Palatine

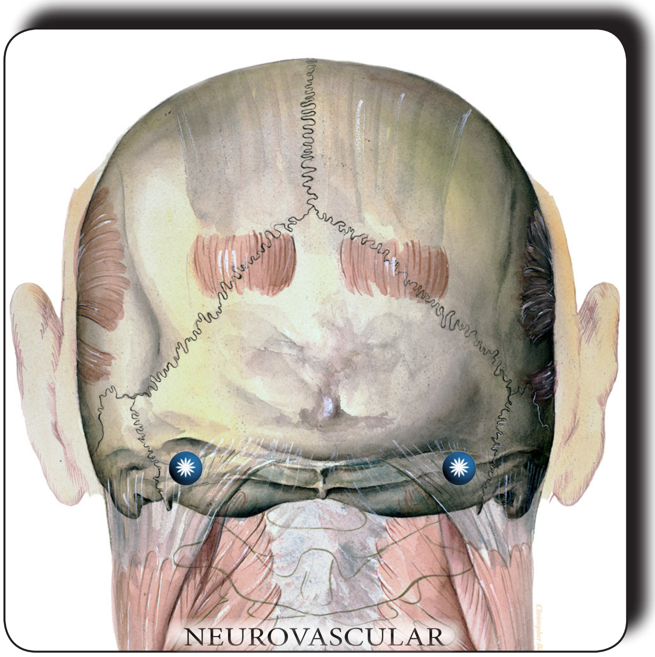
FOOT: 1st Metatarsal

NUTRIENT SOURCE: Lutecium
1. Core Prostate
2. Herb- Red Raspberry





UPPER TRAPEZIUS



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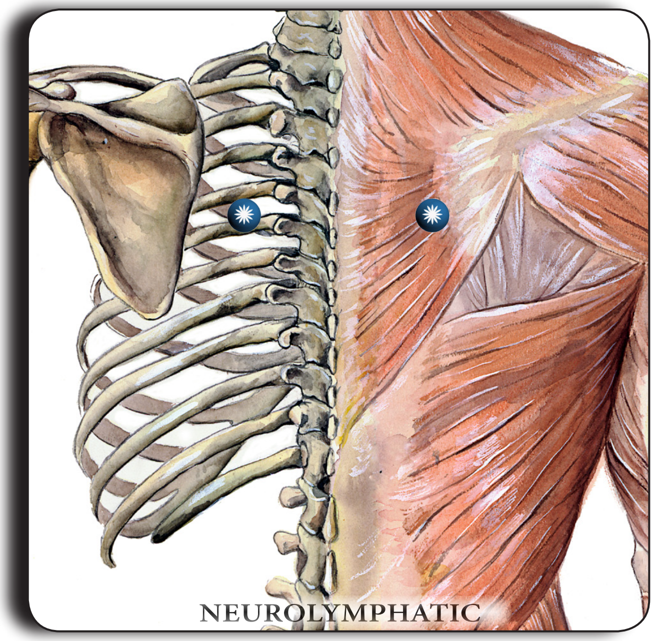

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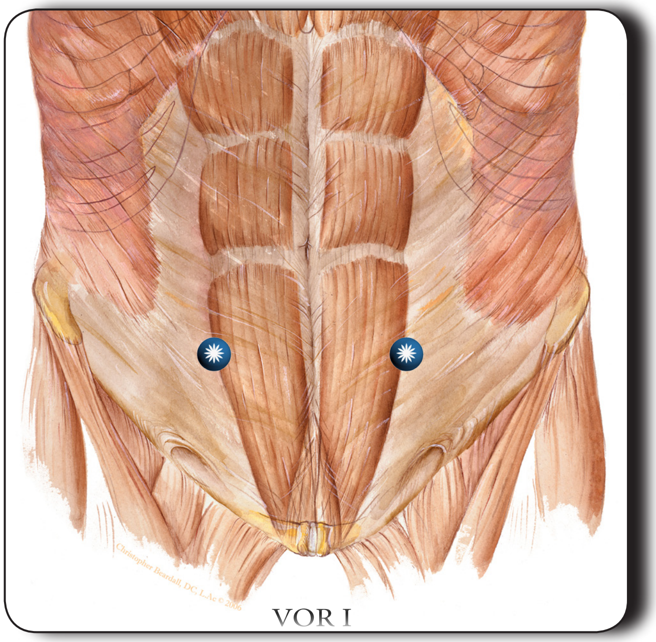
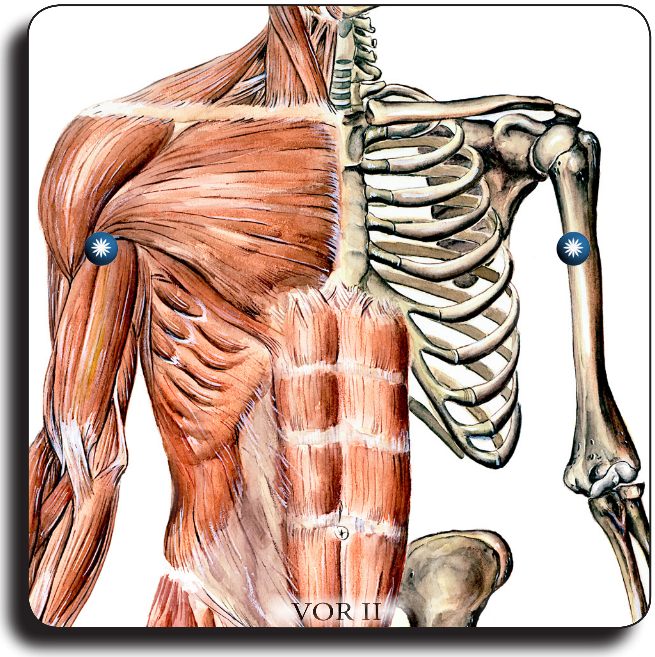

Christopher Beardall, DC L.Ac © 2006

VOR I



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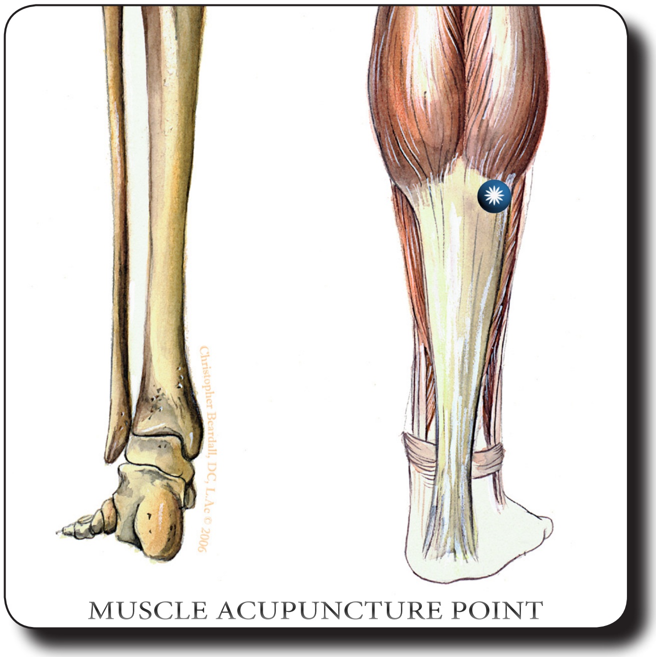
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MUSCLE ACUPUNCTURE POINT

Muscle 270: UPPER TRAPEZIUS, (Scapular Division)

ORIGIN: Ligamentum nuchae and spinous process of C7.

INSERTION: Superior surface acromion process of scapula.

ACTION: With the neck fixed, abducts the scapula drawing it medially toward the cervical column.

TEST:

Patient: Supine and flex arm on shoulder 45°, abduct arm 45°.

Doctor: Position: Ipsilateral. Brace contralateral shoulder. Contact Dorsum of forearm, adduct through coronal plane toward midline.

NEUROVASCULAR: Occipital bone, supra-occipital groove, 1" medial to occipital-mastoid suture, 1/2" superior to base of skull.

NEUROLYMPHATIC: (Post/BL) 5th ICS, 2" lateral to spine.

VISCERAL ORGAN:

I. *Colon:* (Ant/BL) Rectus Abdominis, first section, lateral border.

II. *Eye:* (Ant/BL) Humerus, anterior aspect, insertion of the Pectoralis Major, bicipital groove.

M. A. P. : B58

V.L. : L2L

L. B. V.L. : C4L

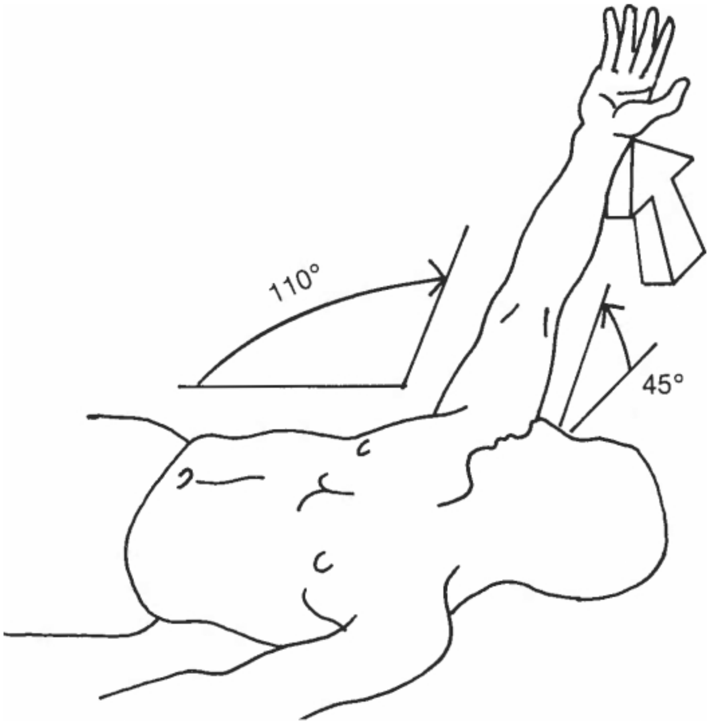
M. M. : C2

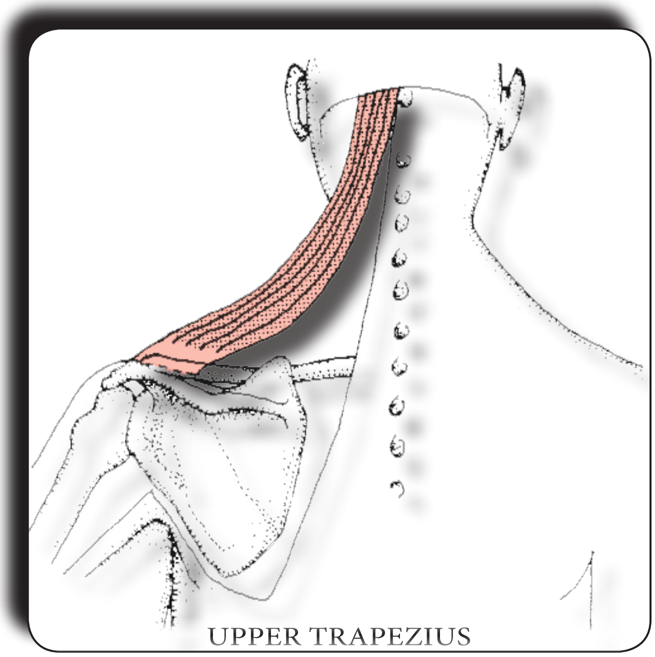
CRANIAL: Occiput

FOOT: Calcaneus

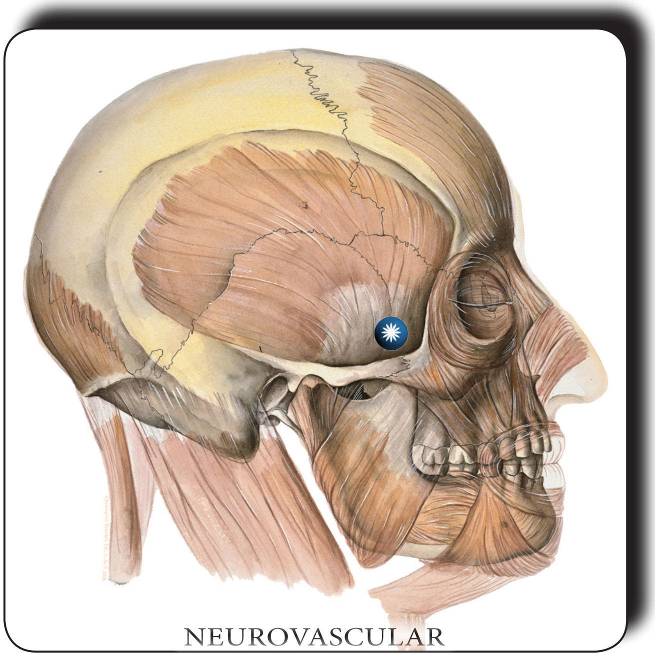
NUTRIENT SOURCE: Selenium

1. Core Selenium(NW)
2. Selenium (NW)
3. Core Thyro (NW)





UPPER TRAPEZIUS



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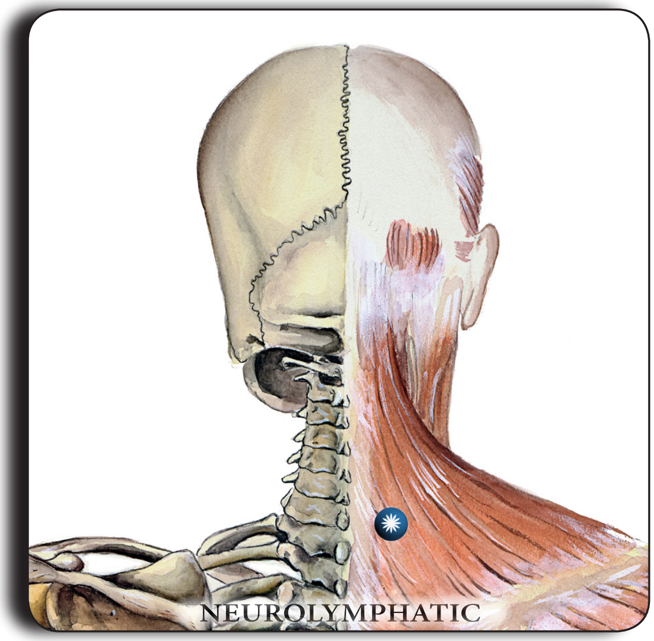

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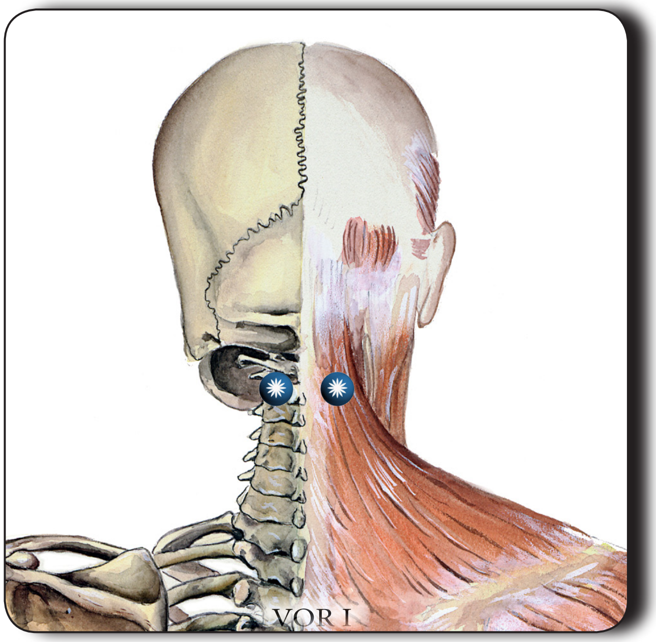

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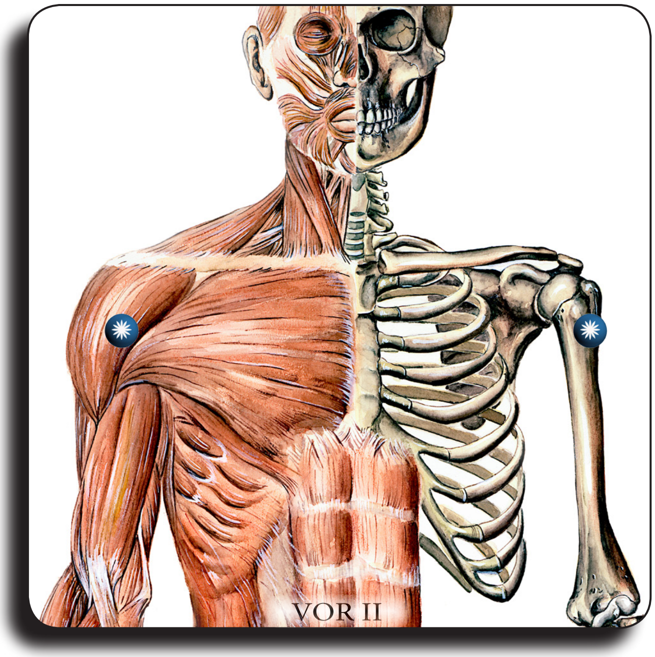

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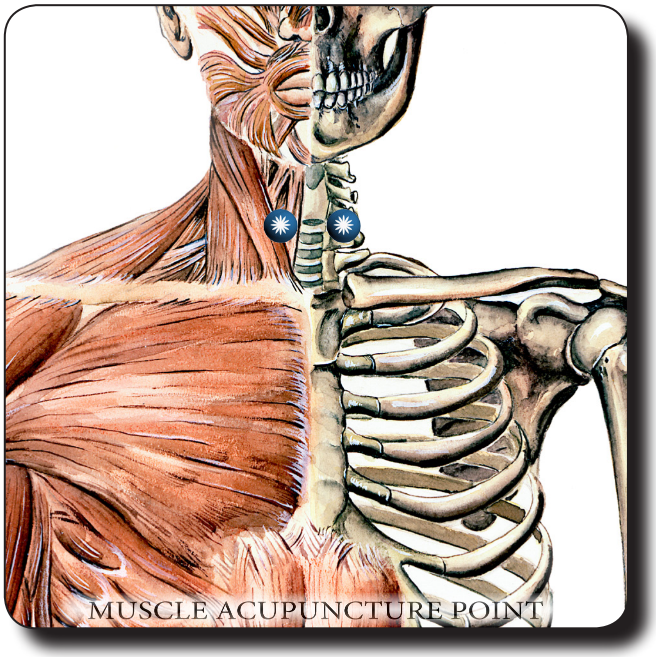


MUSCLE ACUPUNCTURE POINT

Muscle 272: UPPER TRAPEZIUS, (Clavicular Division)

ORIGIN: EOP, medial third of the superior nuchal line of the occiput.

INSERTION: Lateral third of clavicle.

ACTION: With the occiput fixed, abducts the clavicle. With the shoulder fixed, draws the occiput toward the shoulder.

TEST:

Patient: Supine Abduct arm 120° and Rotate arm internally until thumb faces anterior.

Doctor: Position: Ipsilateral. Brace: Contralateral shoulder. Contact Radial aspect of forearm and adduct arm through coronal plane toward feet.

NEUROVASCULAR: (Lat) Cranium, lateral aspect, temporal sphenoid suture just superior to zygomatic process.

NEUROLYMPHATIC: (Post/R) 1st ICS, 1" lateral to spine .

VISCERAL ORGAN:

I. Thymus: (Post/BL) Neck, posterior, superior aspect, transverse of C2 just lateral to B10.

II. Internal Ear: (Ant/BL) Humerus, anterior superior aspect, distal third of medial side of bicipital groove.

M. A. P. : St10

V.L. : T10L

L. B. V.L. : T1L

M. M. : C3

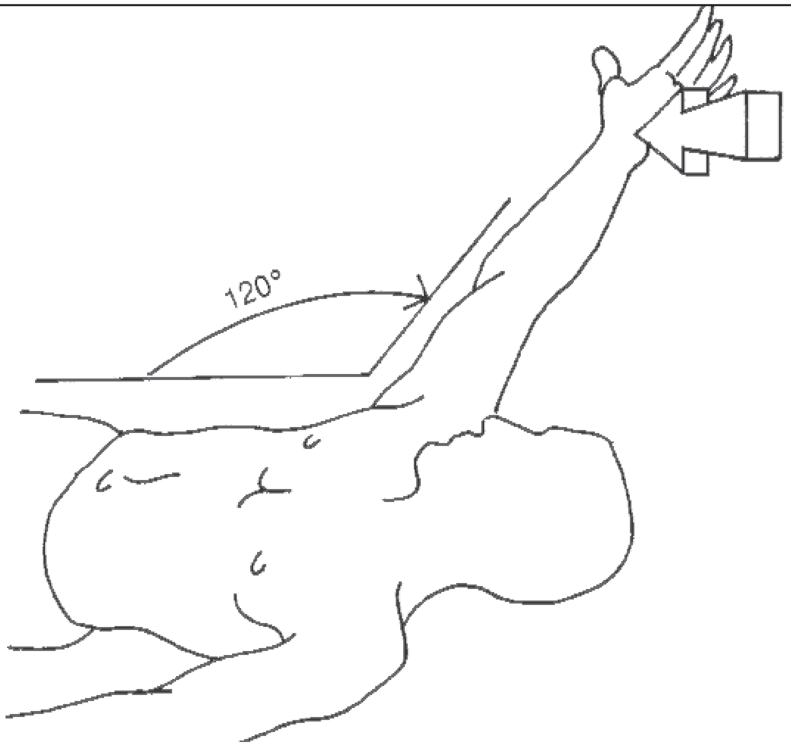
CRANIAL: Maxillary-AP

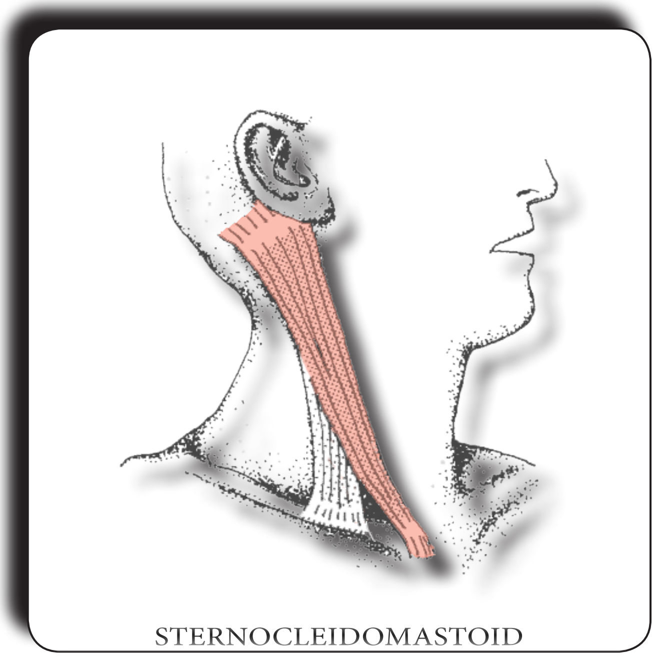
FOOT: 3rd Metatarsal

NUTRIENT SOURCE: Calcium

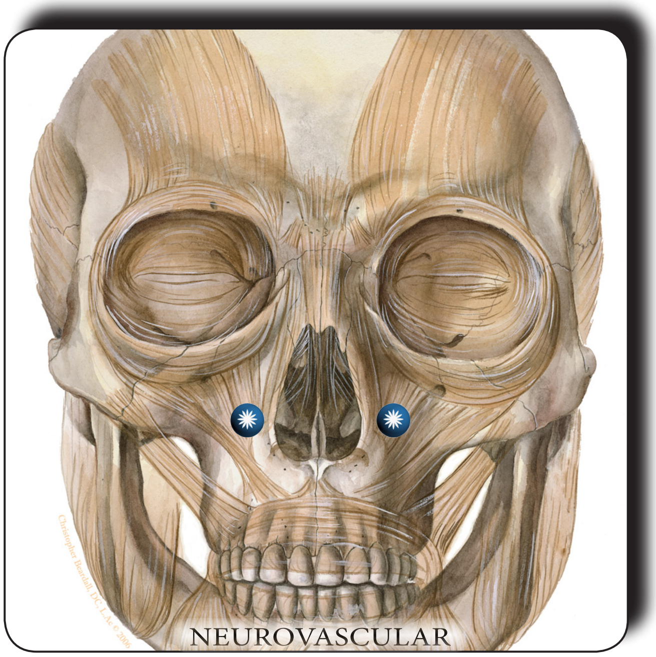
1. Core Calcium (NW)
2. Core Bone Matrix (NW)

Note: Primary support for Supraspinatus





STERNOCLEIDOMASTOID



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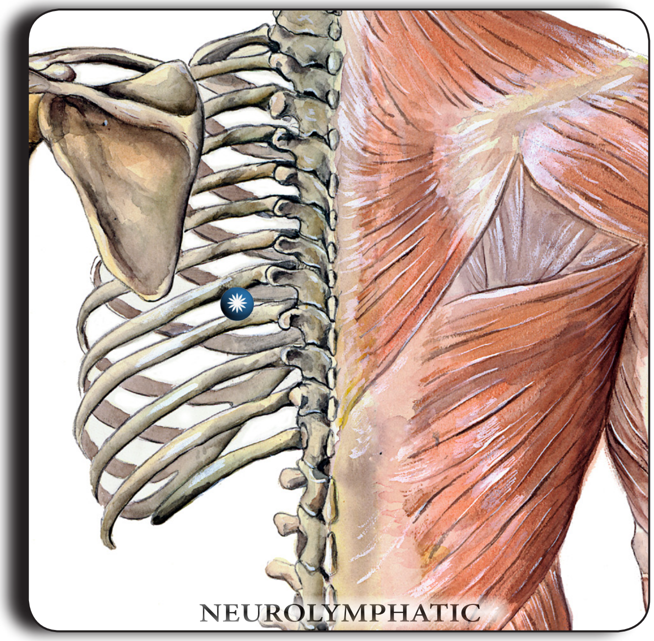

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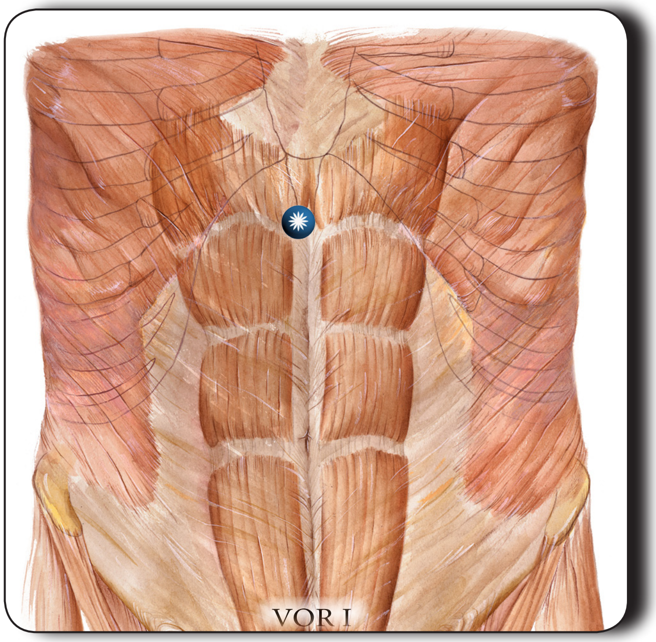
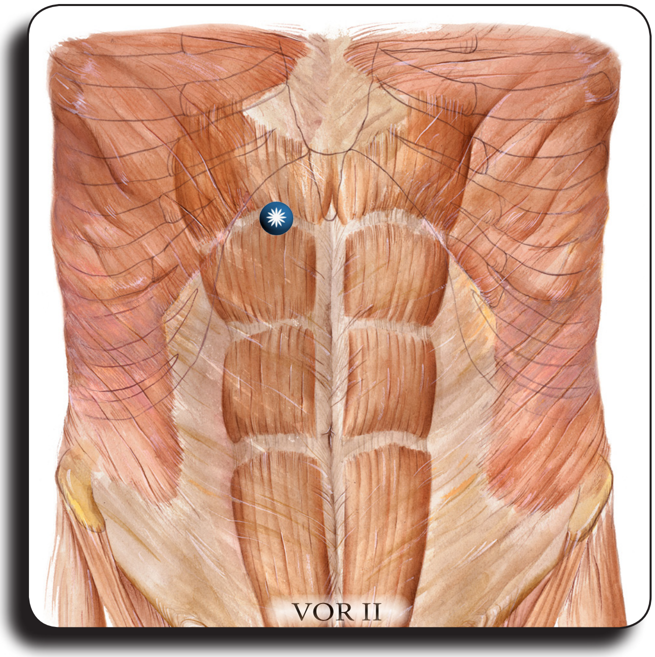


VOR I



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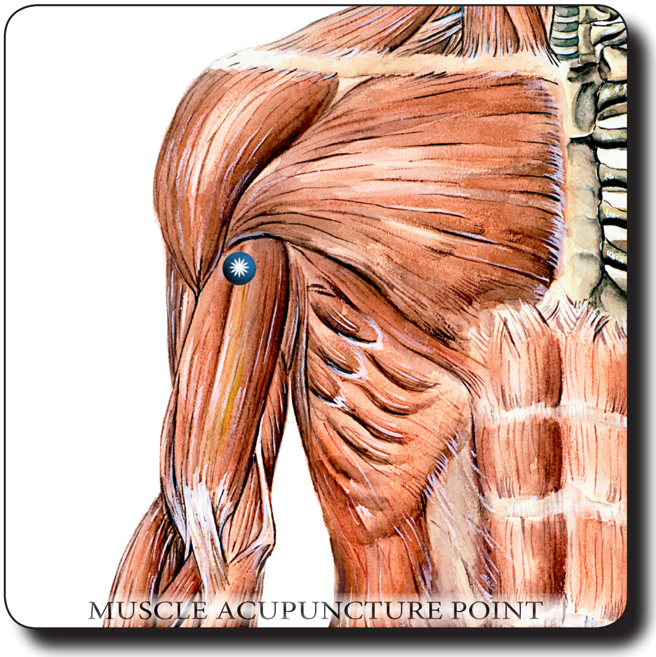


MUSCLE ACUPUNCTURE POINT

Muscle 274: STERNOCLEIDOMASTOID, (Sternal Division)

ORIGIN: Anterior superior surface of manubrium.

INSERTION: Lateral surface of mastoid of the temporal bone.

ACTION: The muscle of one side draws the head toward the shoulder of the same side and at the same time rotates it pointing the chin upward and to the opposite side.

TEST:

Patient: Supine Rotate head 45° away from testing side. Flex neck on trunk 45°.

Doctor: Place palm of hand over TMJ and temporal bone and extend neck sagittally.

NEUROVASCULAR: (Ant/BL) Maxillary bone, level of zygomatic arch, 1/2" lateral to the nose.

NEUROLYMPHATIC: (Post/L) 8th ICS, 1" lateral to the transverse process.

VISCERAL ORGAN:

I. Pancreas: (Ant/R) K21, 1" inferior and 1" lateral to Xiphoid.

II. Gallbladder: (Ant/R) 4th sec. Rectus Abdominus between St19 and K20.

M. A. P. : Cx2

V.L. : T8R

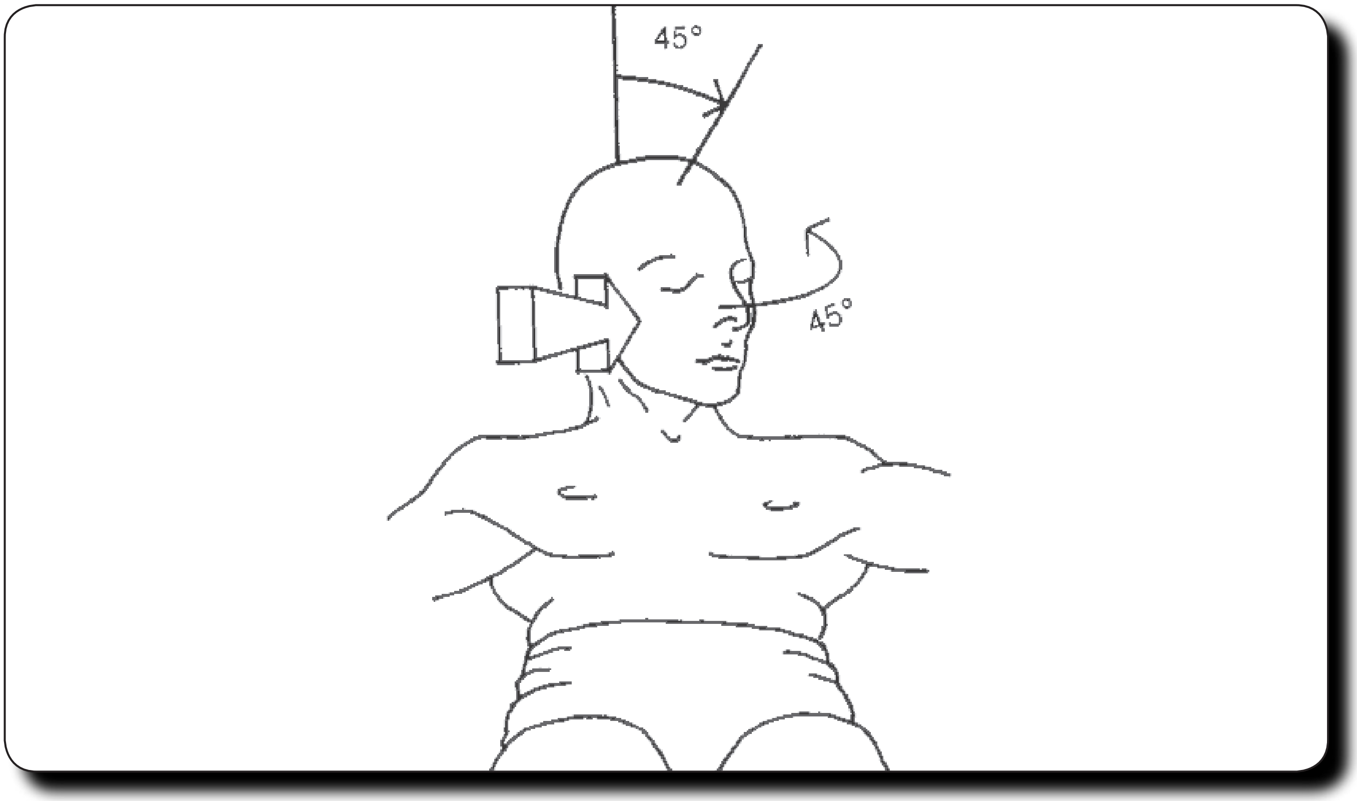
L. B. V.L. : T3R

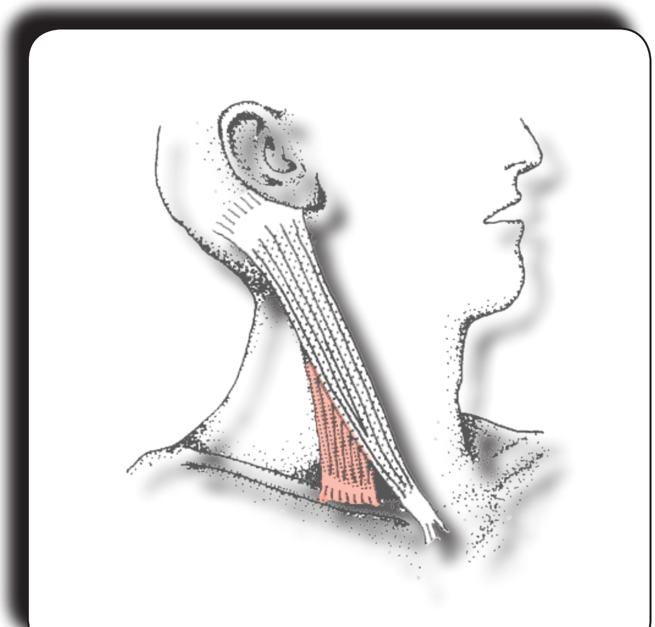
M. M. : C2

CRANIAL: Zygoma

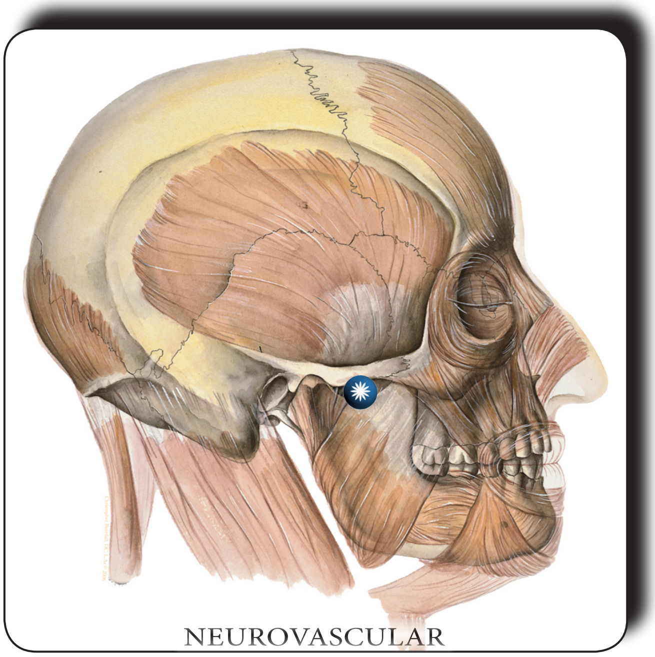
FOOT: In Research

NUTRIENT SOURCE: Selenium
1. Core Selenium (NW)
2. Core Thyro (NW)





STERNOCLEIDOMASTOID



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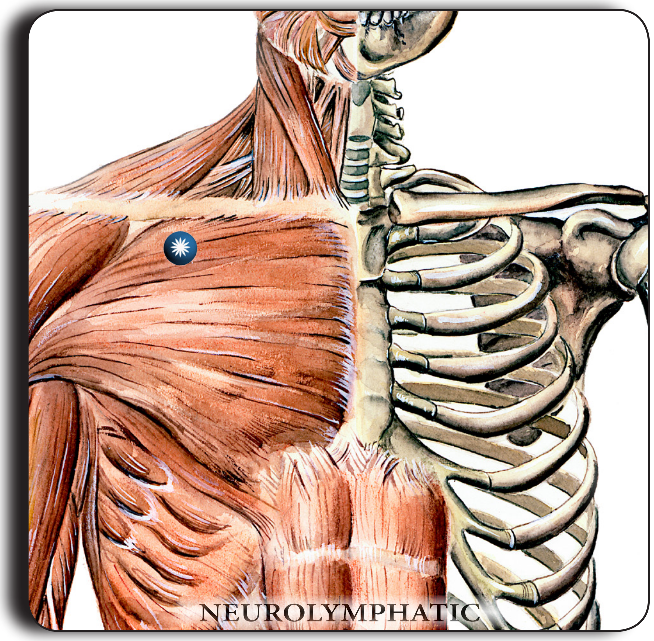

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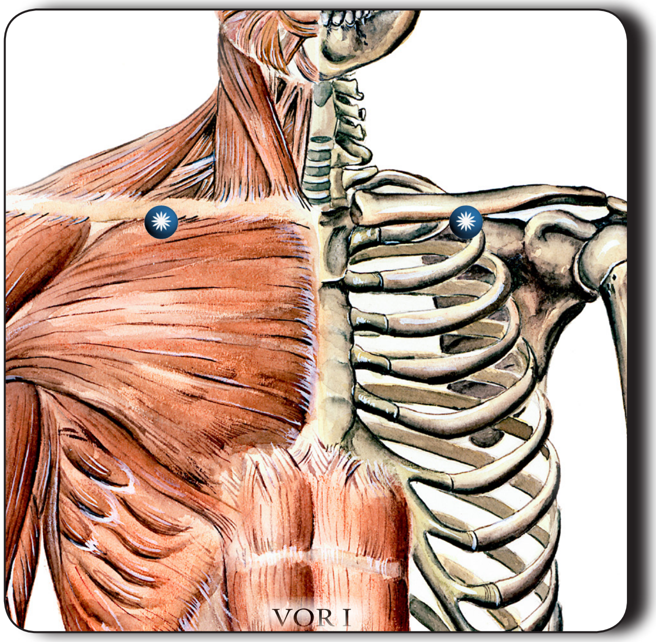

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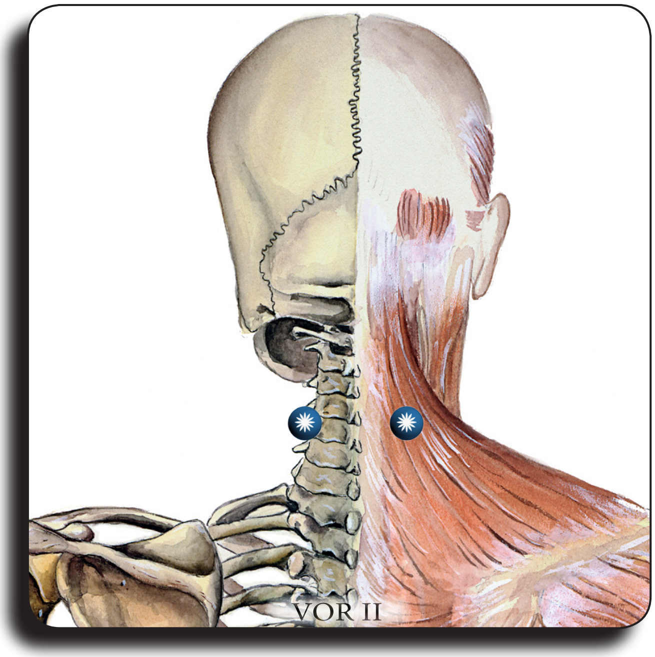

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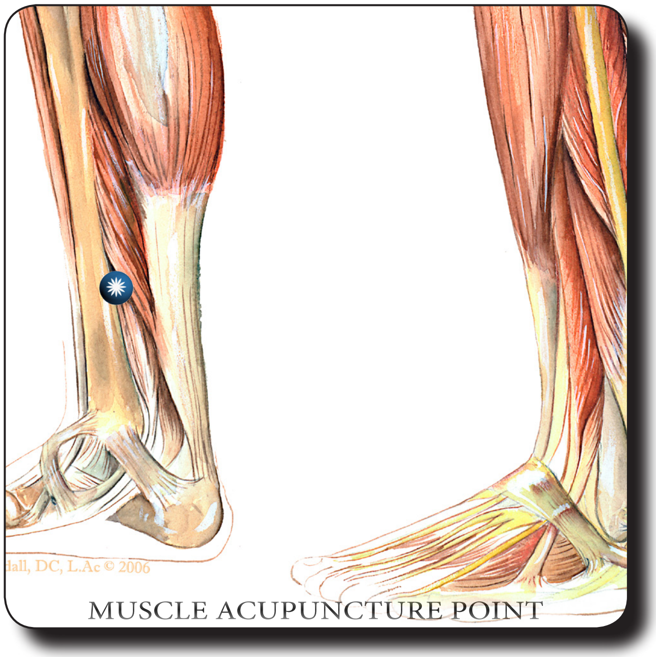


dall, DC, L.Ac © 2006

MUSCLE ACUPUNCTURE POINT

Muscle 276: STERNOCLEIDOMASTOID, (Clavicular Division)

ORIGIN: Superior border and anterior surface of the medial 1/3 of clavicle.

INSERTION: Lateral surface of mastoid and lateral half of superior nuchal line of occiput.

ACTION: Similar to 274 except this division is more concerned with pulling the occiput toward the clavicle and therefore accentuating head turning.

TEST:

Patient: Supine. Rotate head 45° away from testing side. Flex neck on trunk 45°.

Doctor: Place palm of hand around ear and extend neck obliquely toward the opposite ear.

NEUROVASCULAR: (Lat) Mandible, midway between corocoid process and condyle.

NEUROLYMPHATIC: (Ant/R) 1st ICS, on the mid-clavicular line.

VISCERAL ORGAN:

I. Submandibular lymphatics of face and neck: (Ant/BL) St13, midclavicular line.

II. Larynx: (Post/BL) Transverse process of C5

M. A. P. : Lv5.8

V.L. : T6R

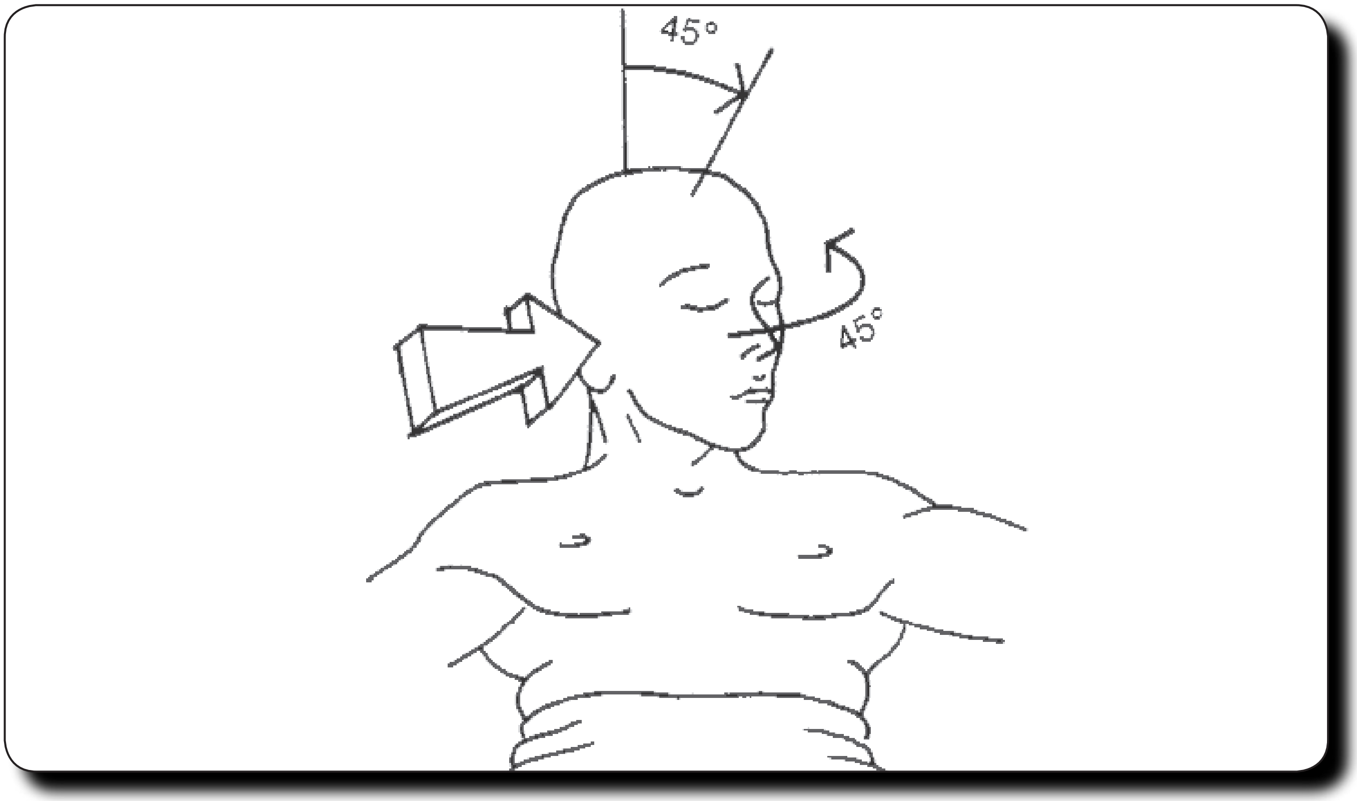
L. B. V.L. : T5R

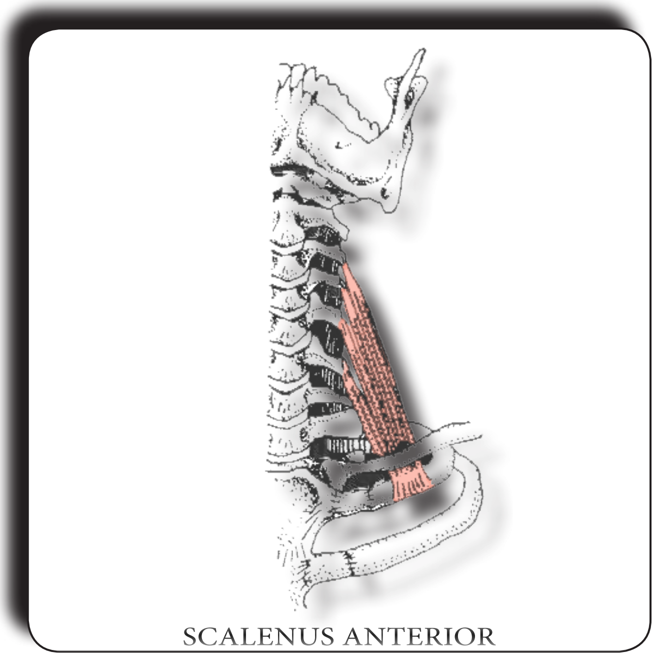
M. M. : C3

CRANIAL: Glabella

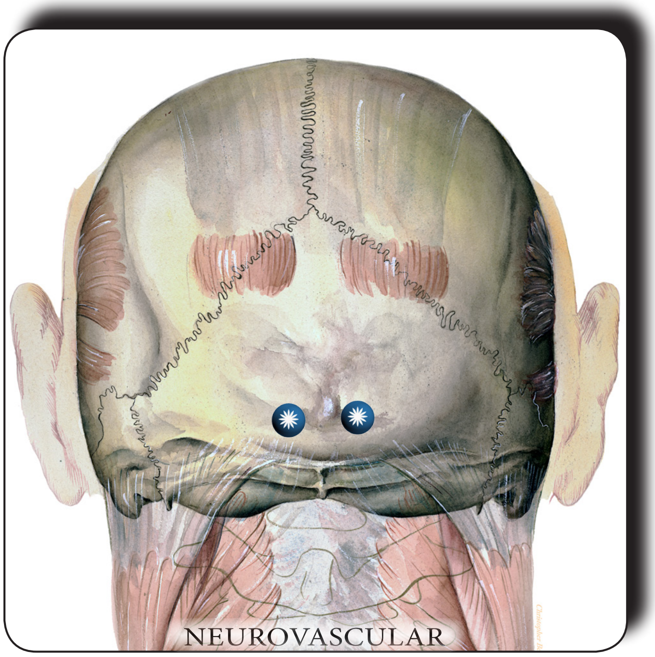
FOOT: 4th Metatarsal

NUTRIENT SOURCE: Niacin
1.Core Niacin (NW)
2. Core Health Reserve
3. B-Complex

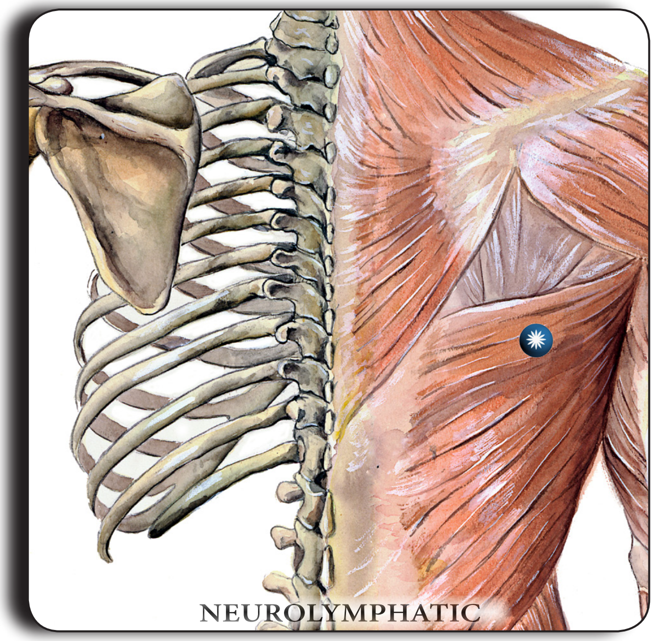




SCALENUS ANTERIOR



NEUROVASCULAR



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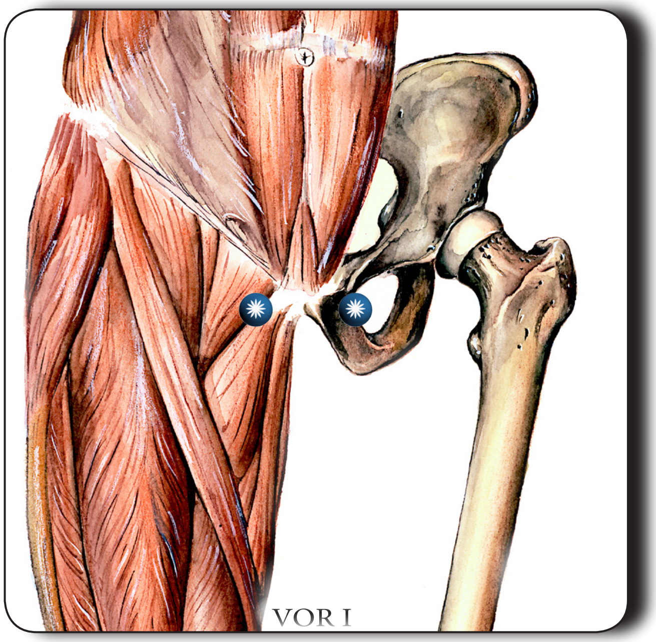

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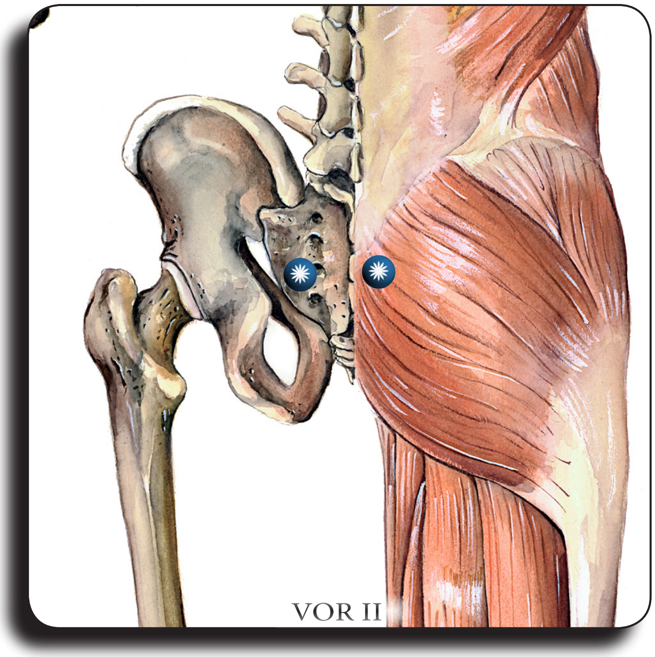

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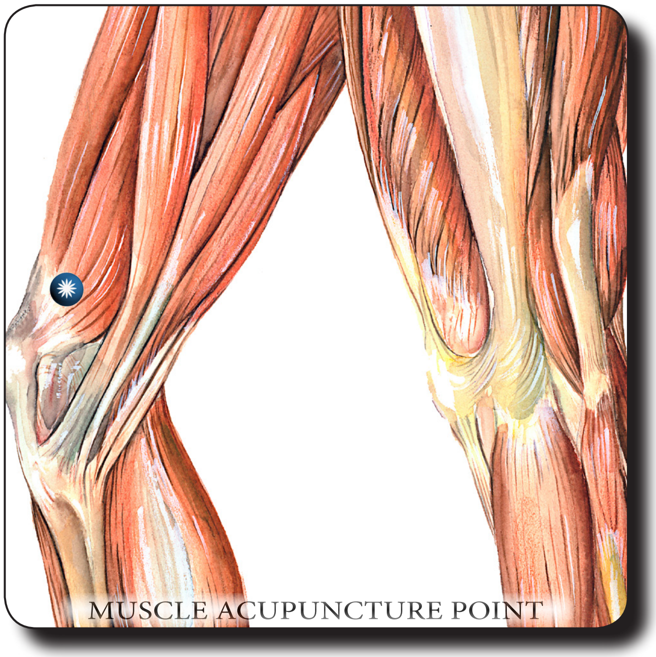


MUSCLE ACUPUNCTURE POINT

Muscle 278: SCALENUS ANTERIOR

ORIGIN: Anterior tubercle of transverse processes of C3 - C6.

INSERTION: Scalene tubercle on superior and posterior border of 1st rib.

ACTION: Raises the first rib. With the rib fixed flexes and rotates the neck slightly.

TEST:

Patient: Supine. Flex neck on trunk 45°. Rotate head 20° away from side tested. Sagittally extend head on neck.

Doctor: Place lateral aspect of hand on maxillary and frontal bone. Extend neck on trunk.

NEUROVASCULAR: (Post/BL) Occipital bone, just lateral to EOP.

NEUROLYMPHATIC: (Post/R) 9th ICS, 6" lateral to spine.

VISCERAL ORGAN:

I. *Ductus Deferens:* (Ant/BL) origin of pectineus, 1" lateral and inferior to K11.

II. *Bladder:* (Post/BL) B28.5, 1/2 way between B28 and B29.

M. A. P. : Sp10

V.L. : L1R

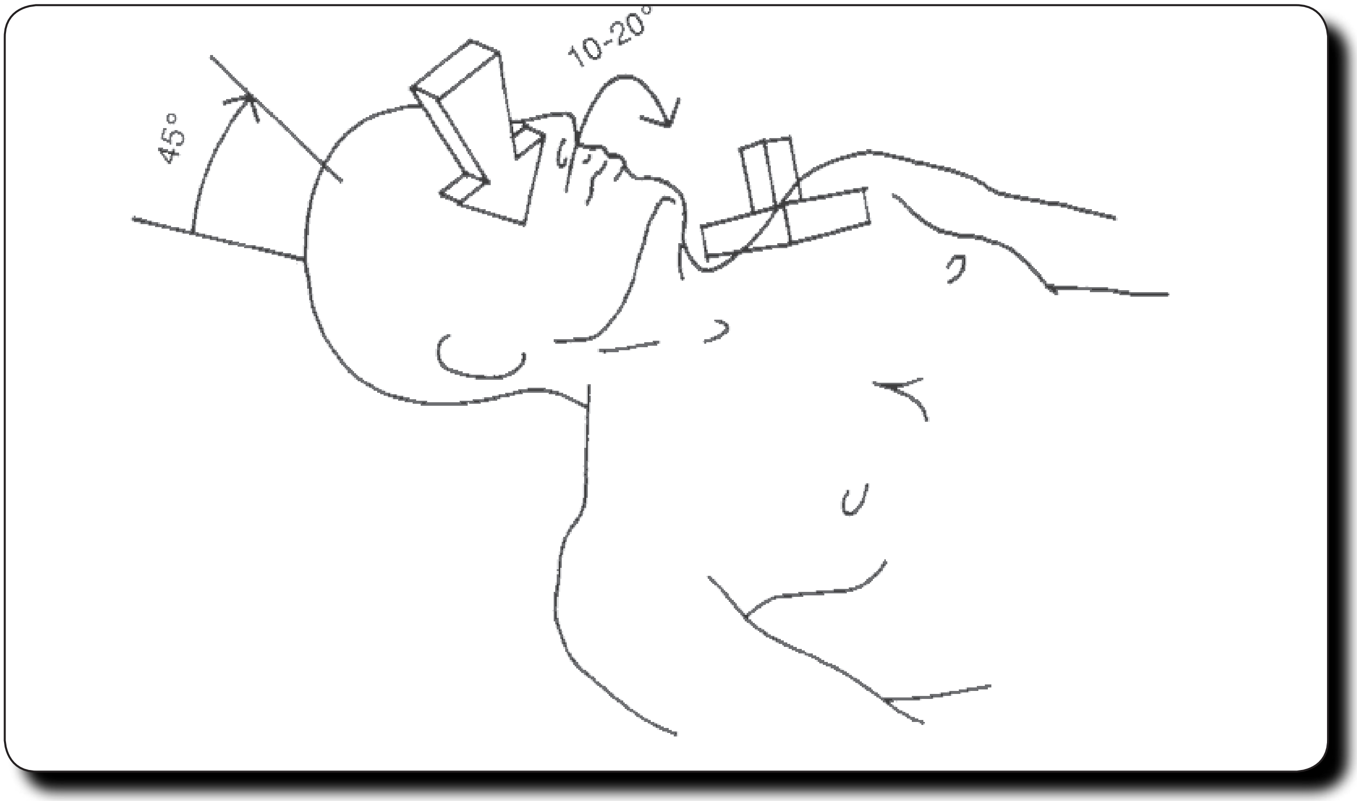
L. B. V.L. : C5R

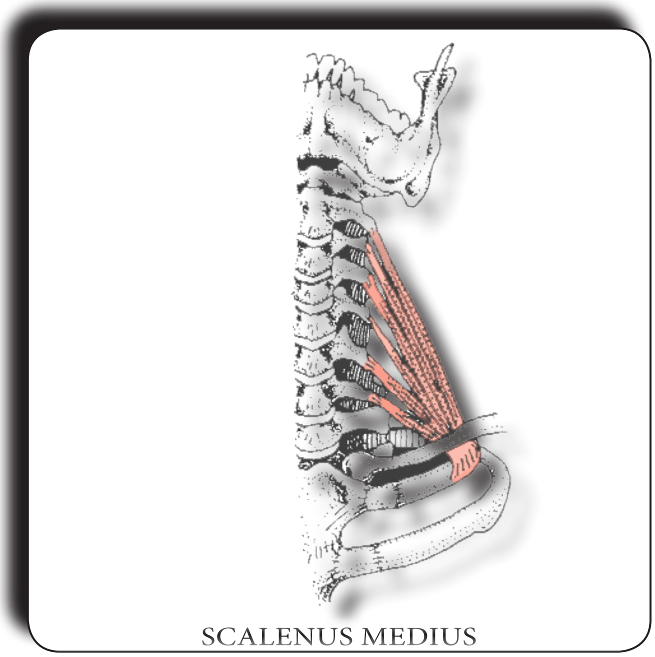
M. M. : C4

CRANIAL: Parietal Bulge

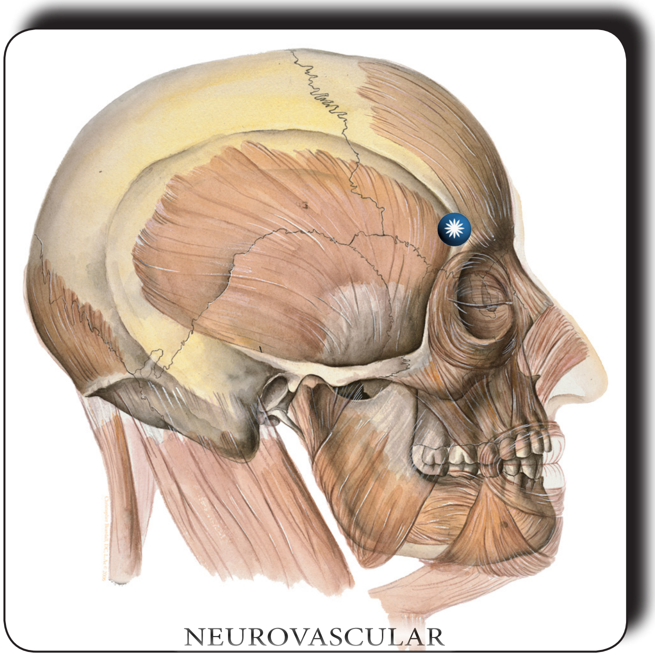
FOOT: Talus

NUTRIENT SOURCE: Iridium
1. Core Kidney

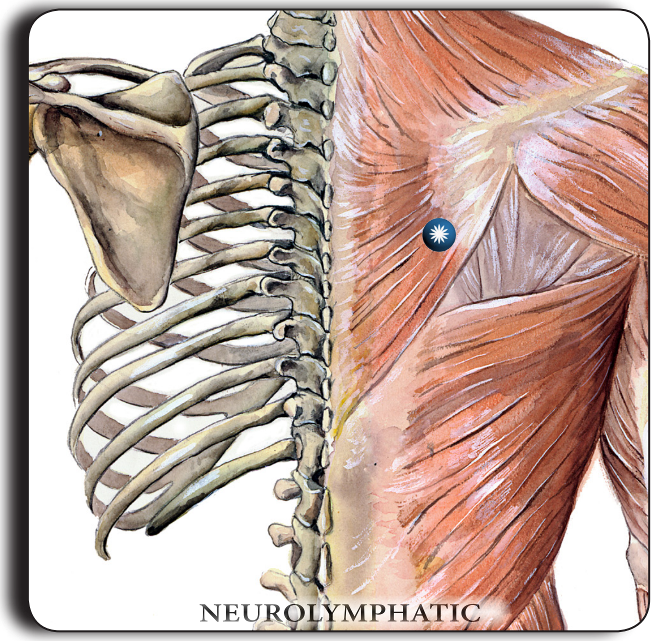




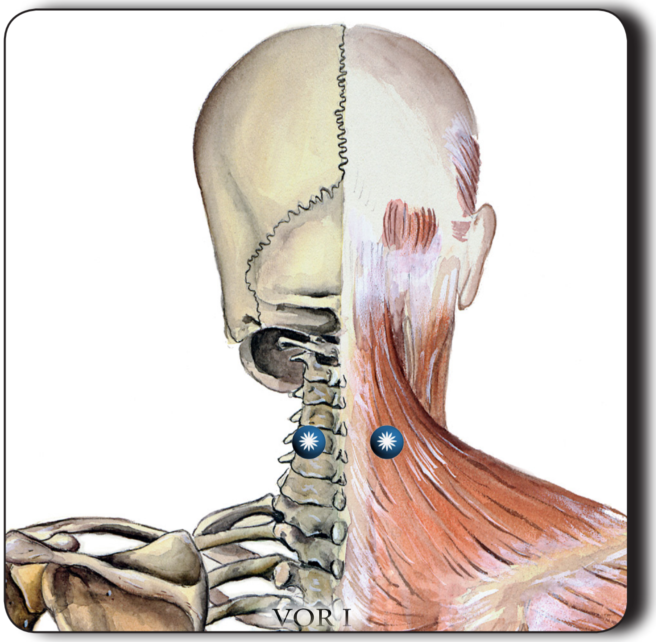
SCALENUS MEDIUS



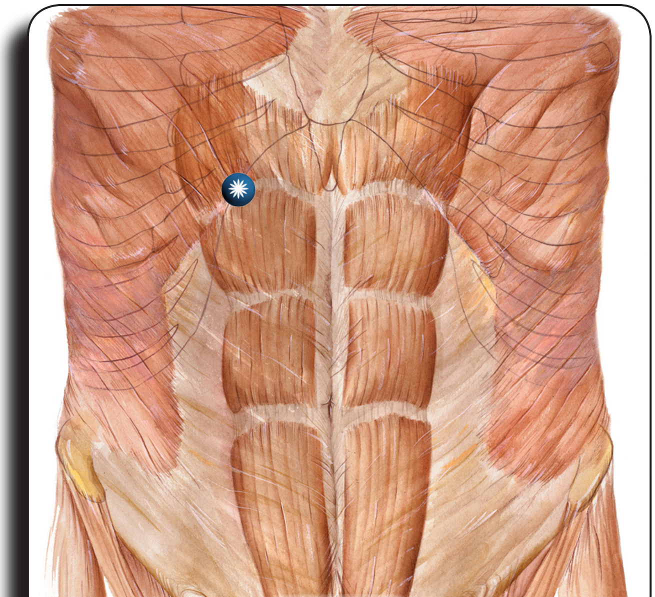
NEUROVASCULAR



NEUROLYMPHATIC



VOR I



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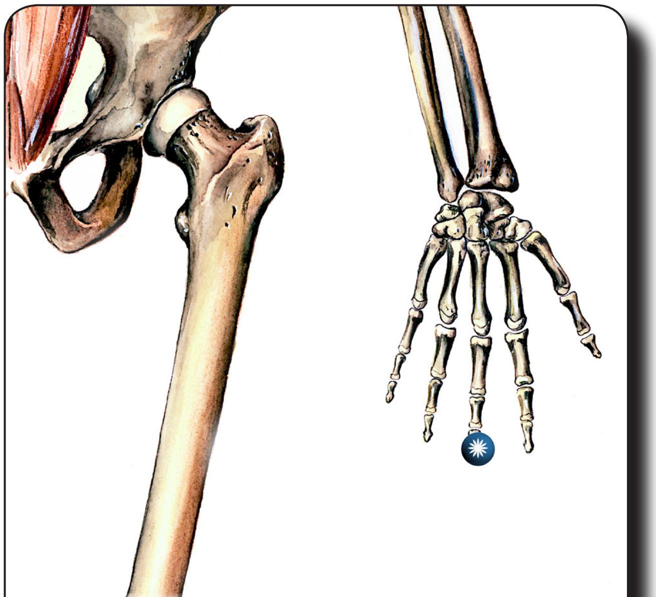


MUSCLE ACUPUNCTURE POINT

Muscle 282: SCALENUS MEDIUS

ORIGIN: Upper surface of 1st rib.

INSERTION: Transverse process of C2 - C7.

ACTION: With the 1st rib fixed, laterally bends and rotates the neck on the trunk.

TEST:

Patient: Supine. Flex neck on trunk 45°. Rotate head 10-20° toward opposite side of test. Coronally extend head on neck.

Doctor: Brace contralateral shoulder, extend neck obliquely.

NEUROVASCULAR: (Ant) Frontal bone, Superior temporal line, just superior to supra-orbital margin

NEUROLYMPHATIC: (Post/R) 6th ICS, 3" lateral to spine.

VISCERAL ORGAN:

I. Submandibular lymphatics: (Post/BL) B10.5 of the head and neck, level of C5.

II. Gallbladder: (Ant/R) Origin 4th section Rectus, 1" in from lateral border.

M. A. P. : CX9

V.L. : L4L

L. B. V.L. : C2L

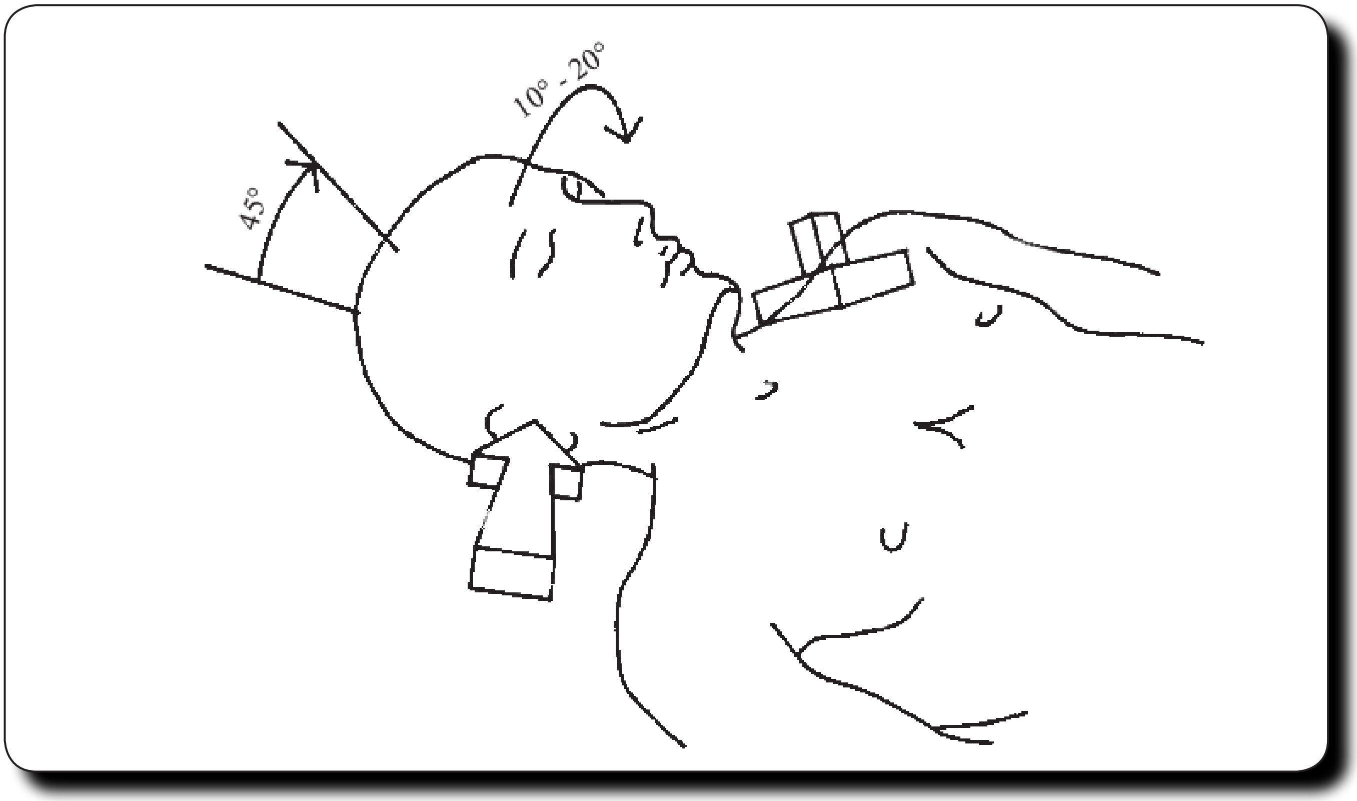
M. M. : C4

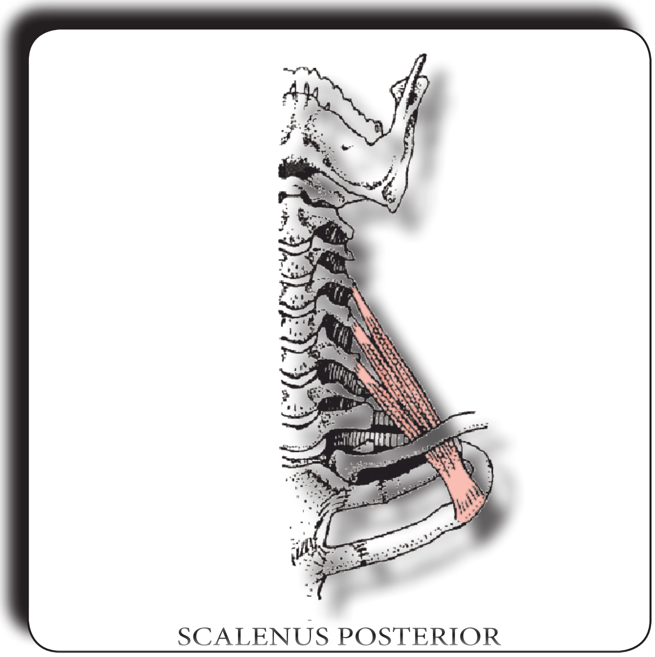
CRANIAL: Lateral Rocker

FOOT: In Research

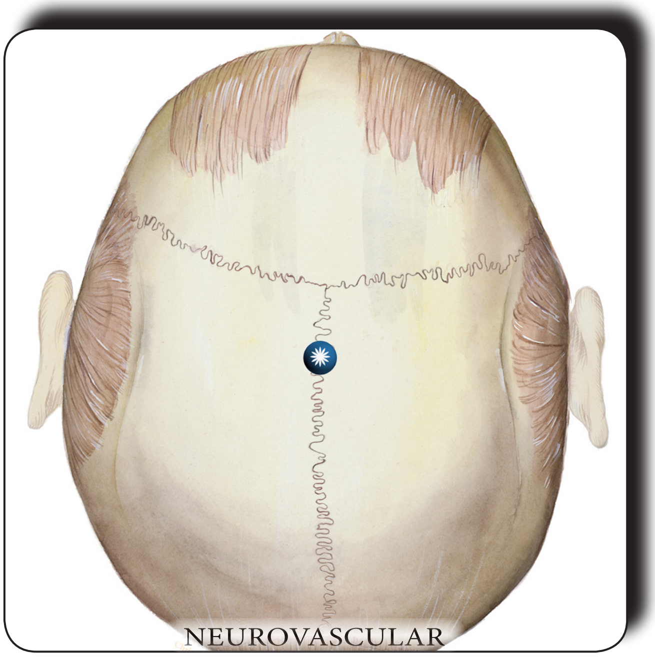
NUTRIENT SOURCE: Biotin

1. Core Heart (NW)
2. Cardioplex (NW)





SCALENUS POSTERIOR



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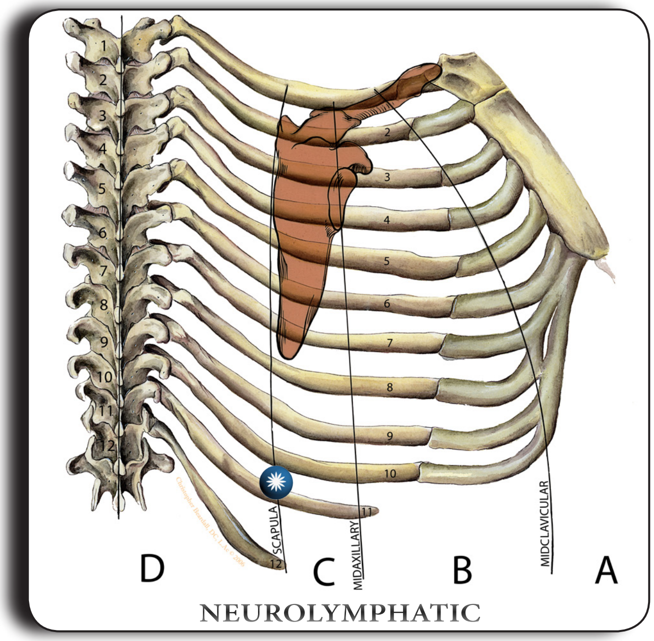
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SCAPULA
MIDAXILLARY
MIDCLAVICULAR
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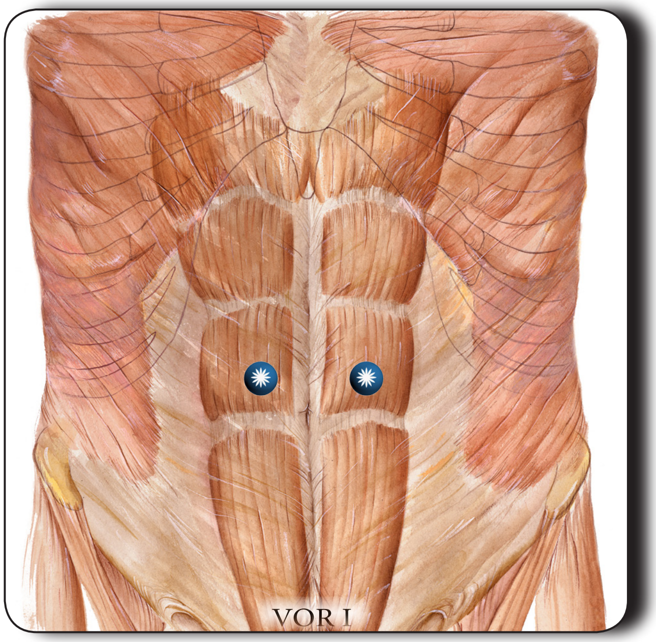
A

NEUROLYMPHATIC



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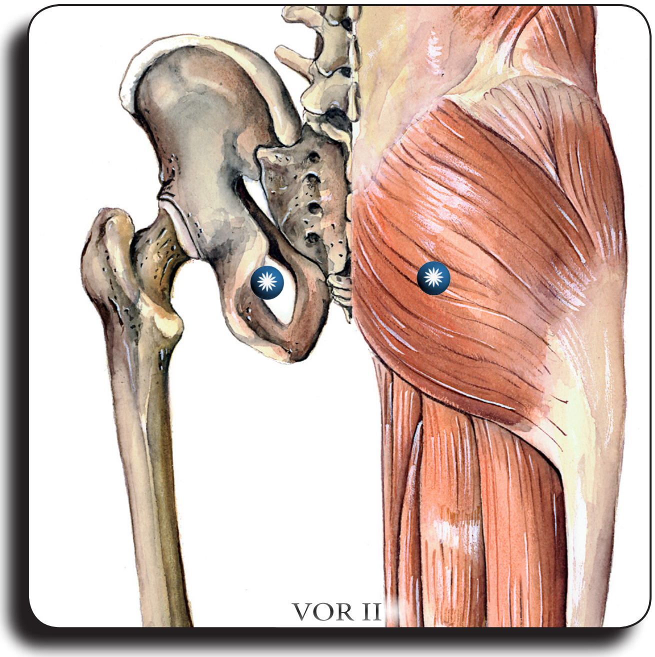

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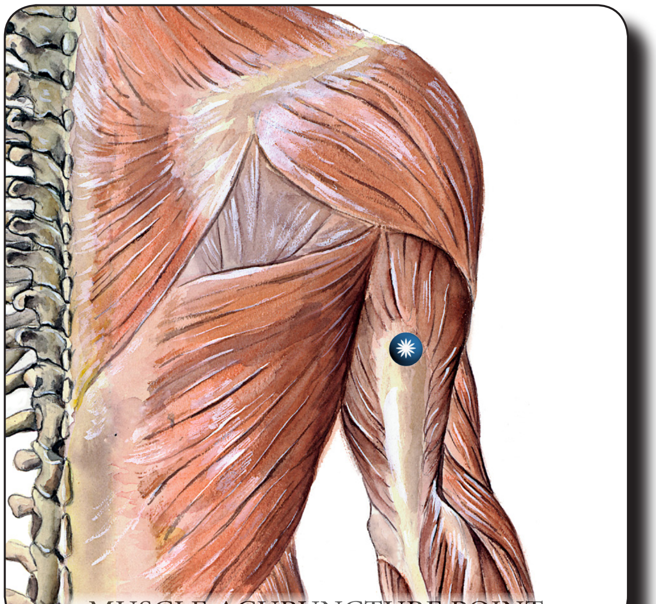


MUSCLE ACUPUNCTURE POINT

Muscle 284: SCALENUS POSTERIOR

ORIGIN: Posterior tubercles of the transverse processes of C4 - C6.

INSERTION: Outer surface of 2nd rib, posterior to tubercle for Serratus Anterior.

ACTION: Raises first and second ribs.

TEST:

Patient: Supine and flex neck on trunk 45°. Rotate head 10-20° toward opposite side of test. Coronally extend head on neck.

Doctor: Brace contralateral shoulder and extend neck coronally.

NEUROVASCULAR: (Sup) Sagittal suture, 2" posterior to anterior fontanel.

NEUROLYMPHATIC: (Lat/R) 10th ICS, mid-axillary line.

VISCERAL ORGAN:

I. Kidney: (Ant/BL) l" superior and 2 1/4" lateral to umbilicus.

II. Urethra - prostate portion: (Post/BL) slightly medial and inferior to ischial spine.

M. A. P. : Tw12.25

V.L. : T12L

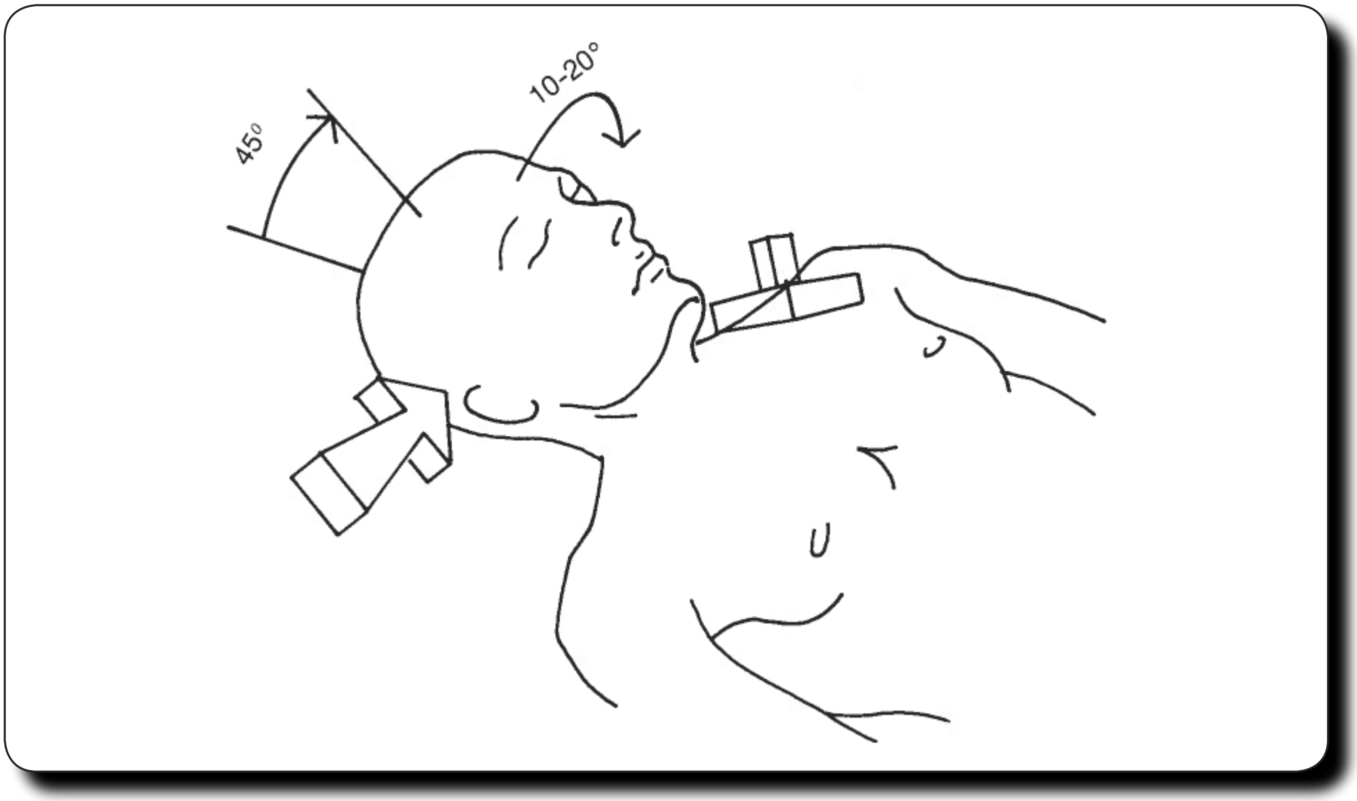
L. B. V.L. : C6L

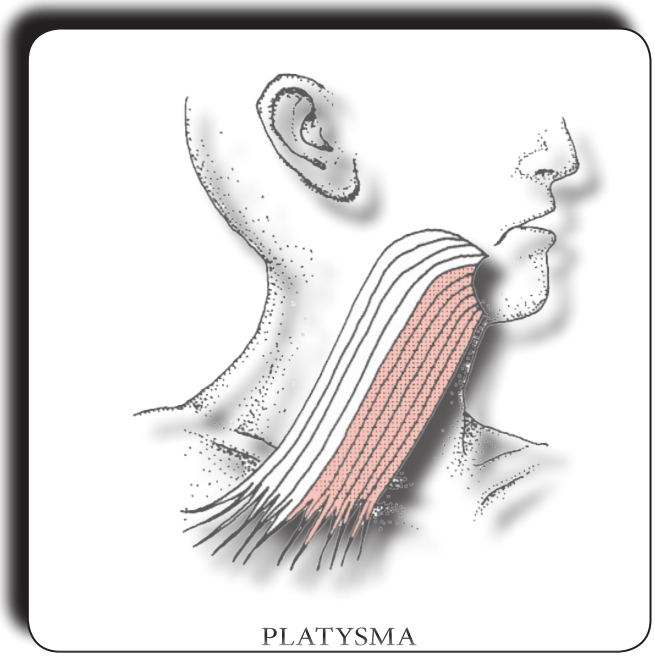
M. M. : C5

CRANIAL: Ethmoid

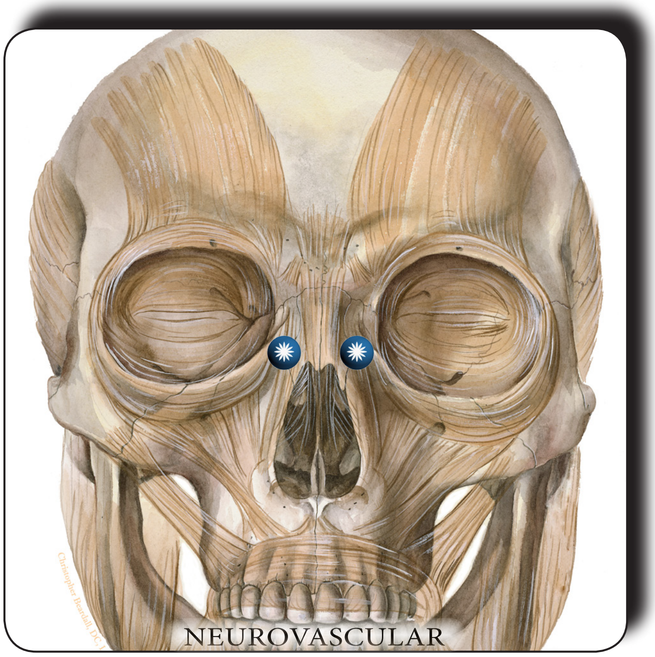
FOOT: 1st Cunieform

NUTRIENT SOURCE: Sodium
1. NaCL (Table Salt)

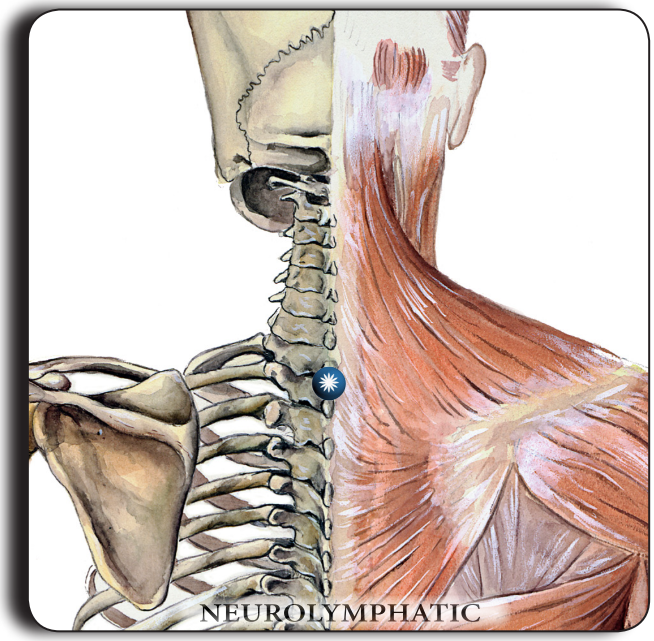




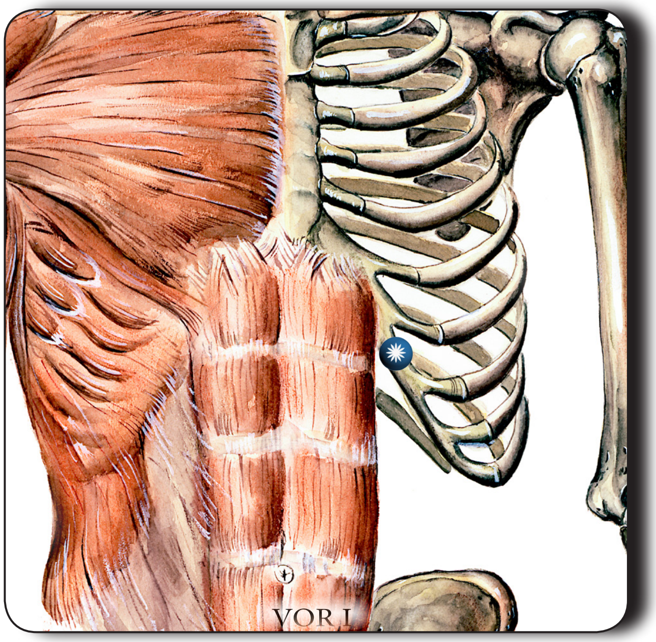
PLATYSMA



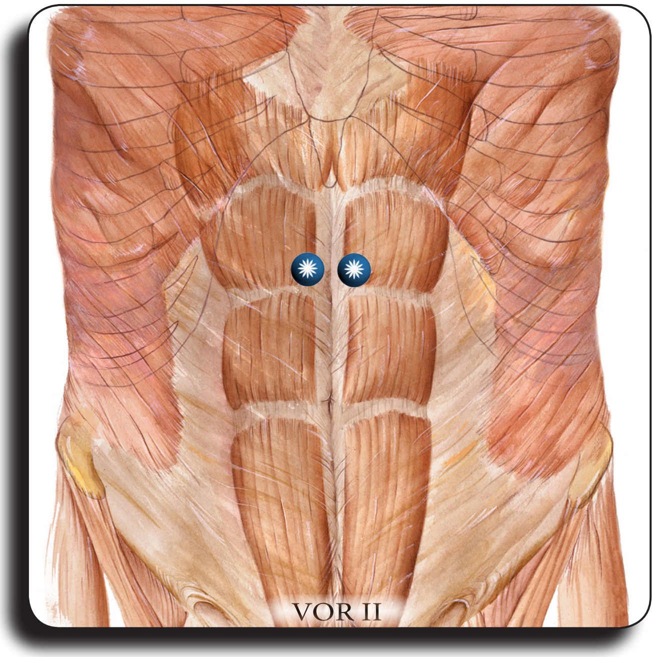
NEUROVASCULAR



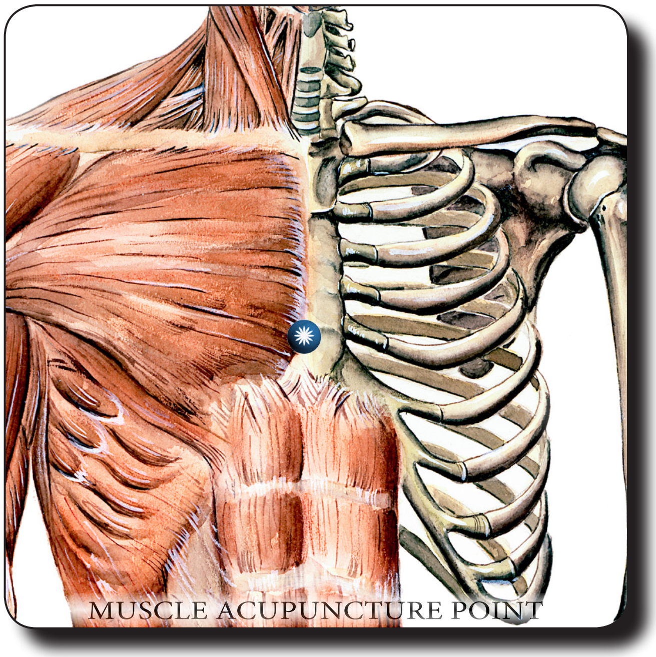
NEUROLYMPHATIC



VOR I



VOR II



MUSCLE ACUPUNCTURE POINT

Muscle 286: PLATYSMA, (Anterior Division)

ORIGIN: Fascia covering the upper parts of the Pectoralis Major and Deltoid.

INSERTION: Anterior fibers interlace below and behind the symphysis menti.

ACTION: Draws the outer part of the lower lip downward and assists in opening the jaw.

TEST:

Expression of horror, lower lips downward, then open jaw slightly. Use indirect muscle test before and during the above. Note change.

NEUROVASCULAR: (Ant/BL) Maxillary and nasal suture at the level of the inferior aspect of the orbit.

NEUROLYMPHATIC: (Post/Midline) Gv 13 between the spinous processes of Tl and T2.

VISCERAL ORGAN:

I. Pancreas - Sugar: (Ant/L) Ribcage. Costocartilage between the 7th and 8th ribs.

II. Duodenum - descending portion: (Ant/BL) Rectus Abdominis, third section, 1/2" superior to the origin of the medial aspect.

M. A. P. : Cv16.5

V.L. : T1R

L. B. V.L. : T10R

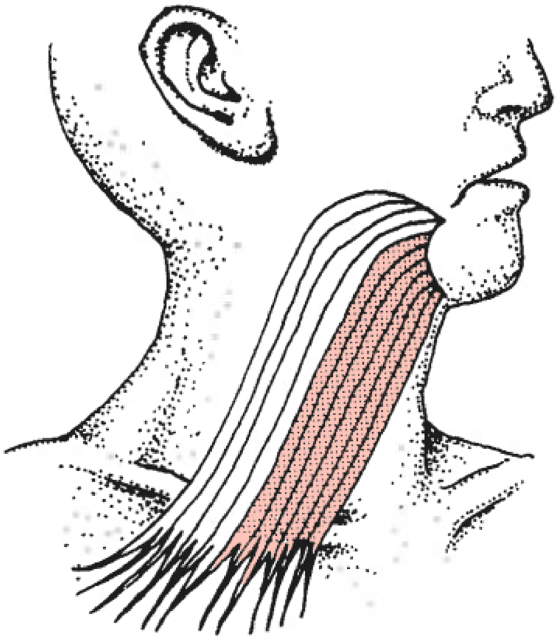
M. M. : CN VII

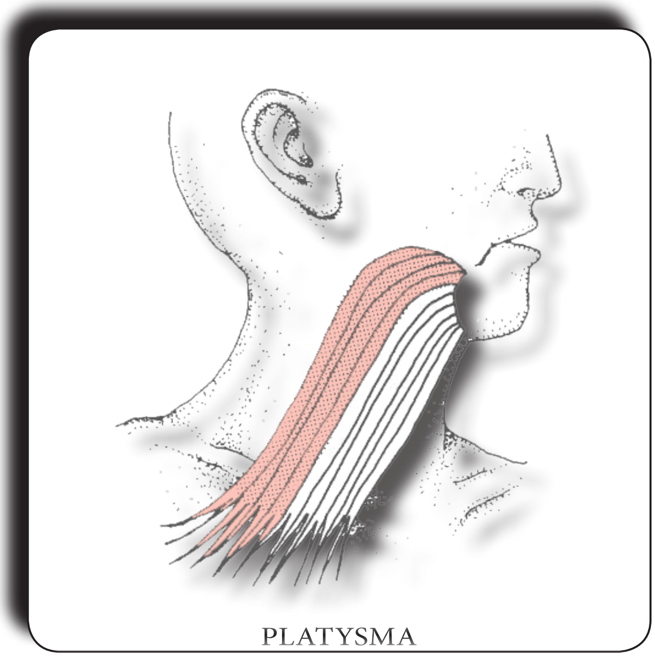
CRANIAL: Zygomatic

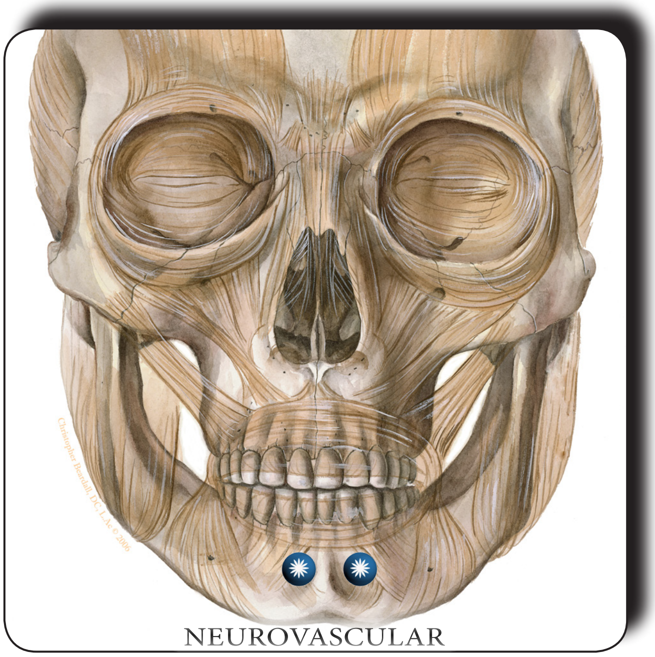
FOOT: 3rd Cuneiform, 4th Metatarsal

NUTRIENT SOURCE: B2 (Riboflavin)

1. Core Health Reserve (NW)
2. B-Complex (NW)
3. Multi-Complex (NW)




PLATYSMA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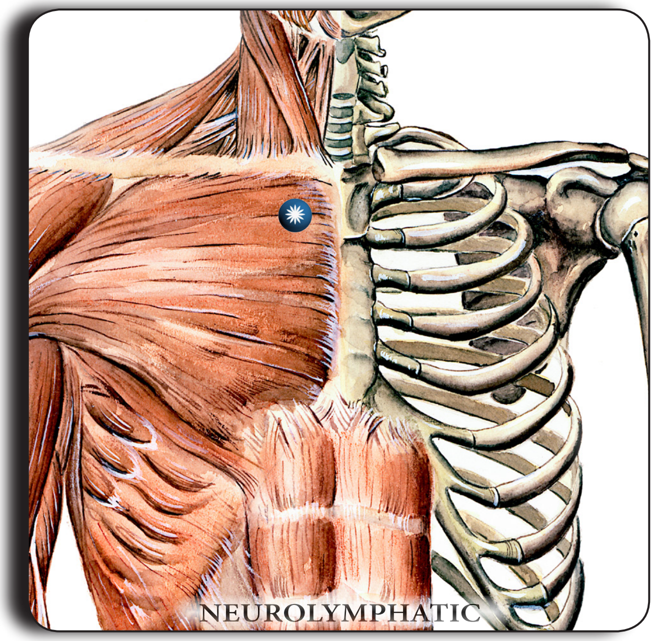
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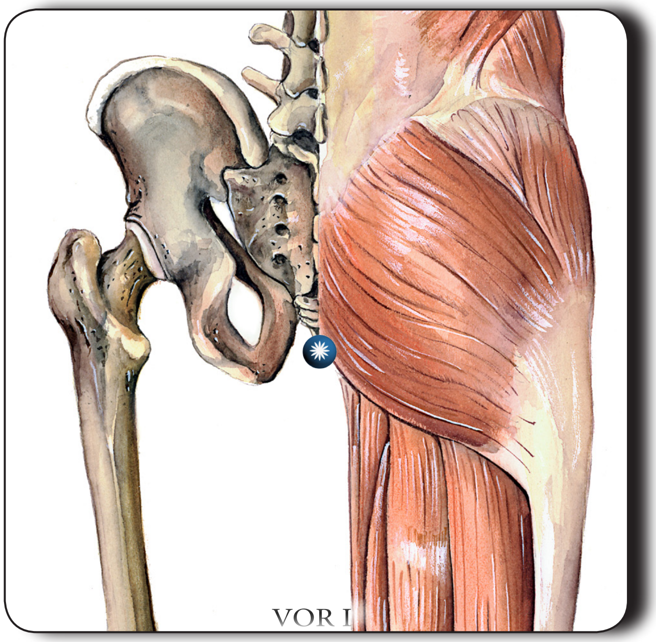
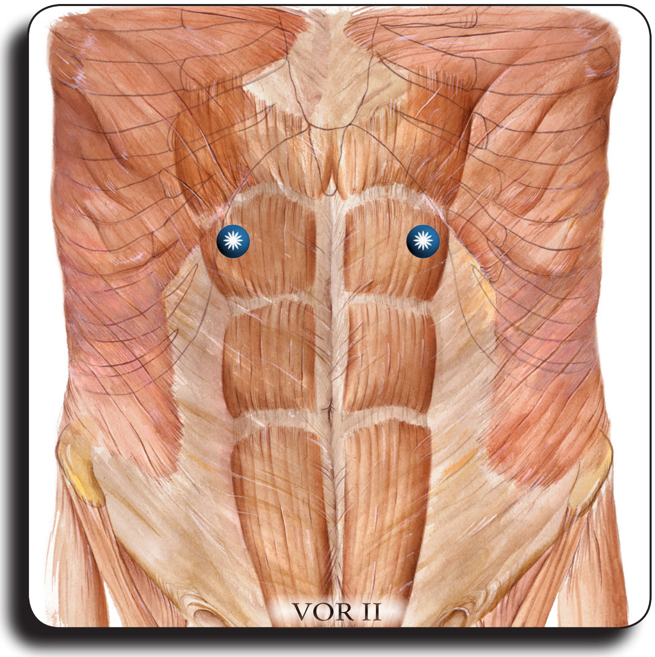

VOR I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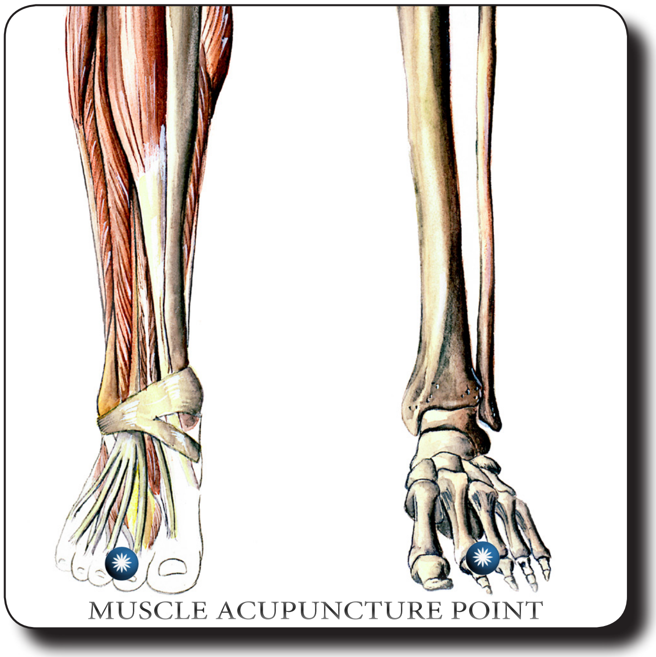

MUSCLE ACUPUNCTURE POINT

Muscle 288: PLATYSMA, (Posterior Division)

ORIGIN: Those fibers whose origin is from the deltoid area. Sometimes called the posterior fibers.

INSERTION: The posterior fibers insert on the mandible below the oblique line and into the facial muscles at the angle of the mouth.

ACTION: Assists in opening the jaw. Draws the outer part of the lower lip backward.

TEST:

Use the indirect muscle test: Follow the directions under action and then retest intact muscle.

NEUROVASCULAR: (Ant/BL) Mandible just lateral to the pogonion.

NEUROLYMPHATIC: (Ant/R) 1st ICS, 1/2" lateral to the sternum.

VISCERAL ORGAN:

I. Rectum - Lymphatics: (Post/Midline) Pelvis, posterior aspect, pelvic floor, 12 o'clock on rectal orifice.

II. Pancreas - Proteolytic: (Ant/BL) Rectus Abdominis, third section, St21.

M. A. P. : St45

V.L. : T11R

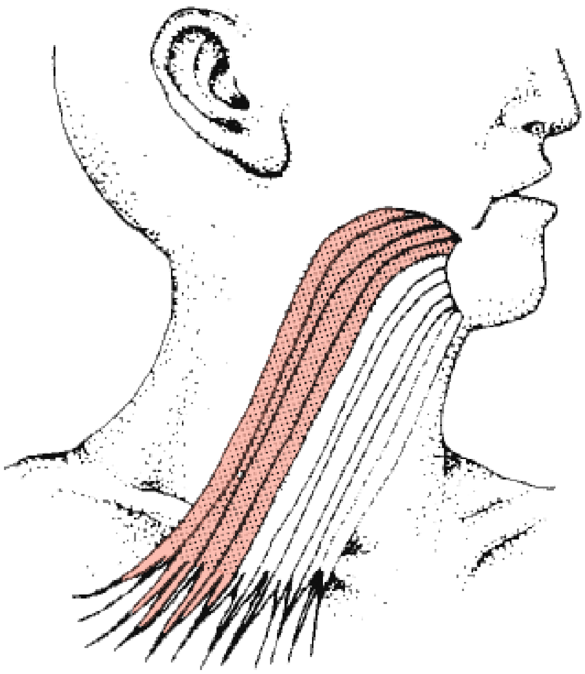
L. B. V.L. : C7R

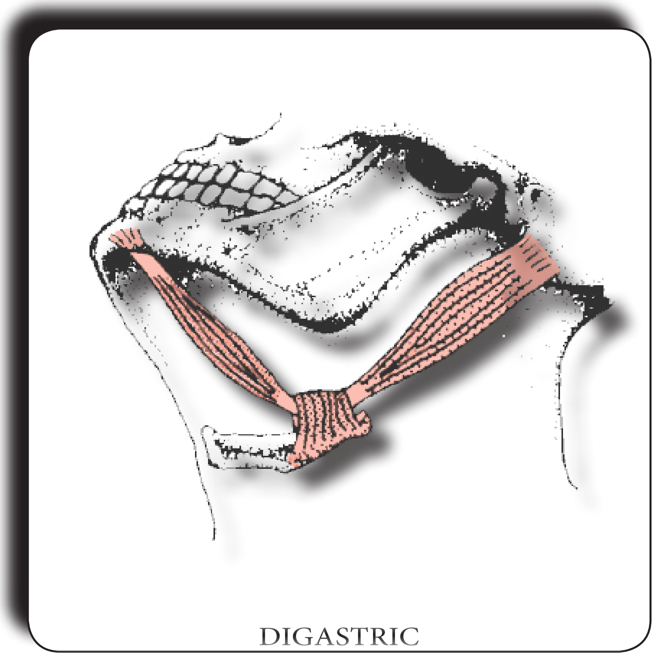
M. M. : CN VII

CRANIAL: Inferior Conchae

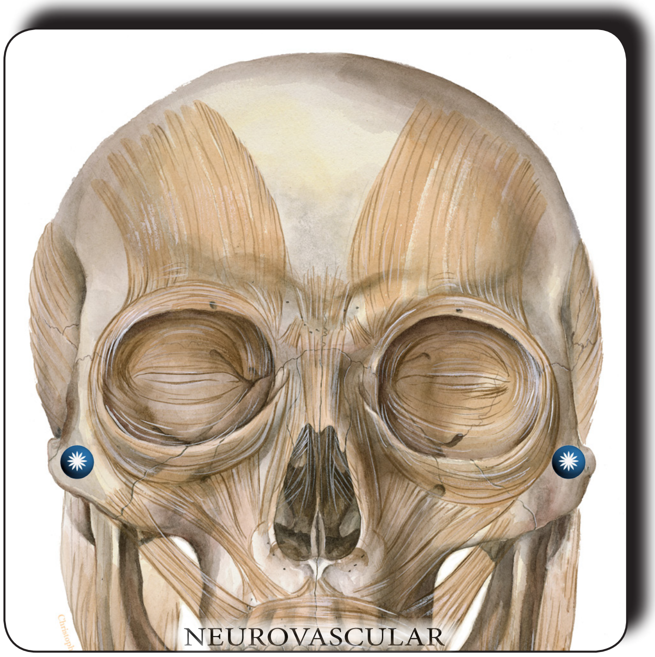
FOOT: 1st phalanx, 2nd toe

NUTRIENT SOURCE: Pantothenic Acid (B5)
1.Core Health Reserve (NW)
2. B-Complex
3. Pantothenic Acid (NW)

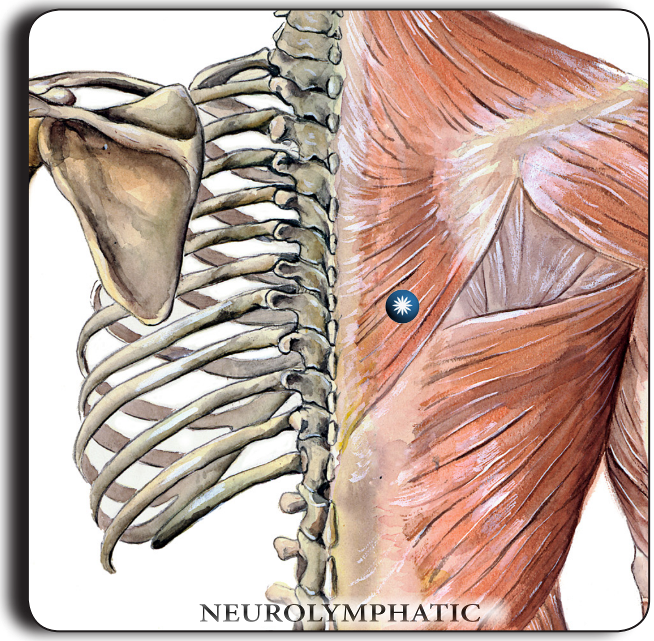




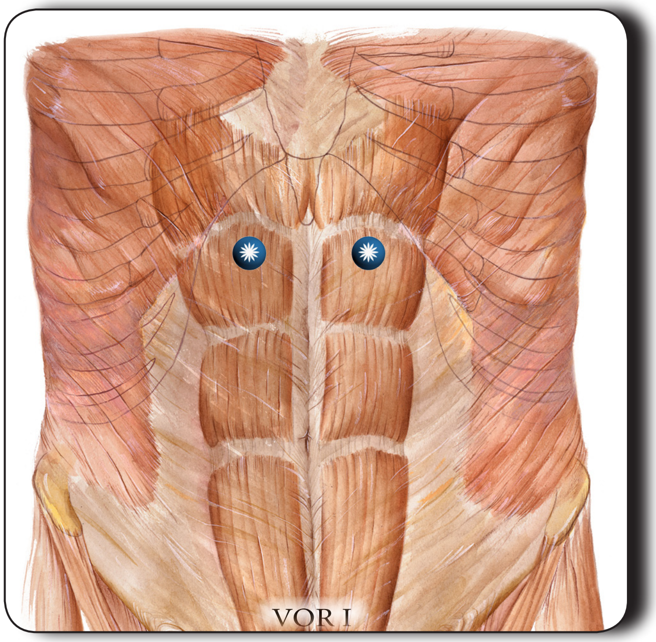
DIGASTRIC



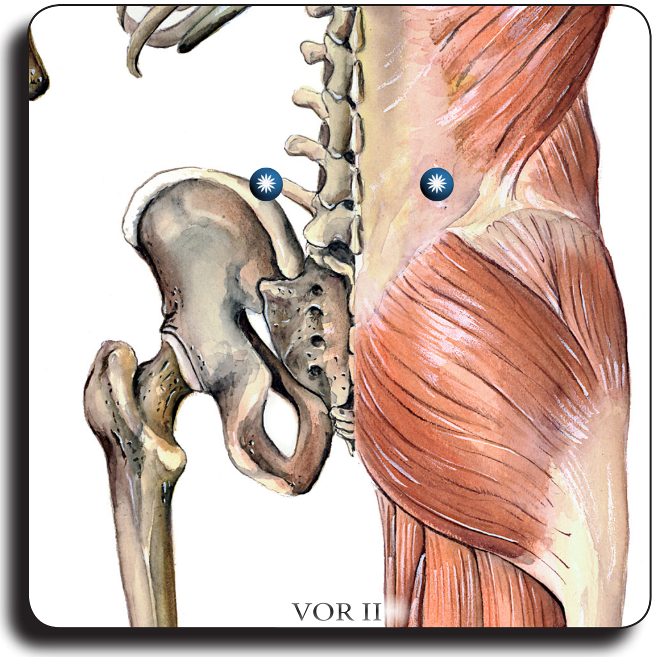
NEUROVASCULAR



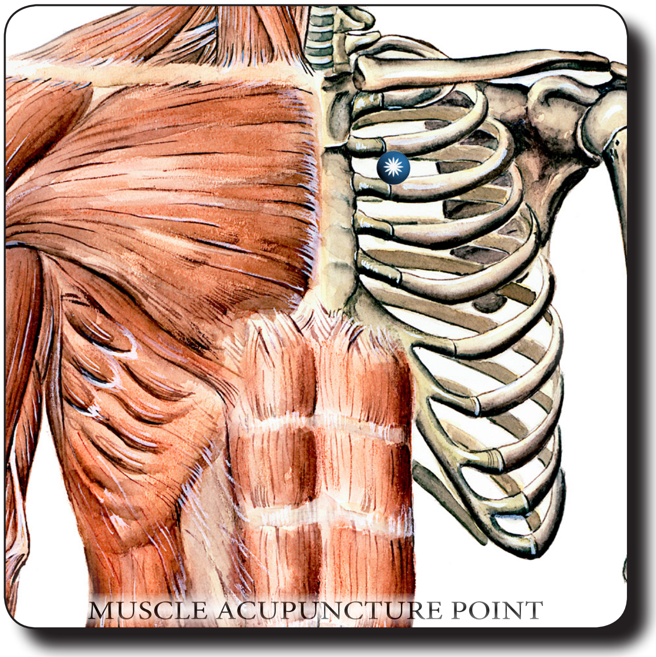
NEUROLYMPHATIC



VOR I



VOR II



MUSCLE ACUPUNCTURE POINT

Muscle 290: DIGASTRIC, (Anterior Belly)

ORIGIN: A depression on the inner side of the lower border of mandible close to the symphysis.

INSERTION: Rounded tendon which is attached to the suprahyoid aponeurosis which arises from the greater cornu of the hyoid

ACTION: Draws the hyoid forward. Assists in opening the jaw and swallowing.

TEST:

TL challenge: Touch belly of anterior division located superior to hyoid, inferior to mandible, 1" inferior to symphysis and 1" lateral to midline.

NEUROVASCULAR: (Ant/BL) Zygomatic bone, at the level of the inferior margin of the eye.

NEUROLYMPHATIC: (Post/R) 8th ICS, 1" lateral to spine.

VISCERAL ORGAN:

I. Pancreatic duct system: (Ant/BL) 3rd section Rectus Abdominus, 2" lateral to midline near its insertion.

II. Bladder: (Post/BL) Crest of ilium, 2" lateral to spinous process of L4.

M. A. P. : K25

V.L. : C3L

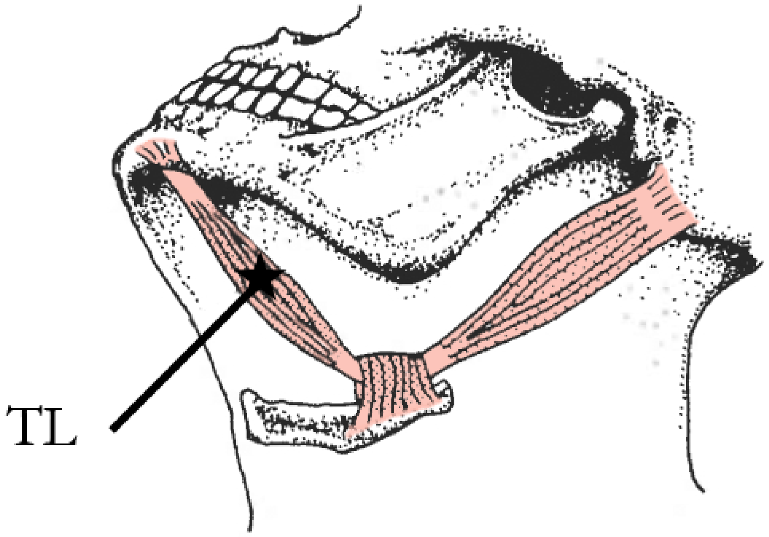
L. B. V.L. : L3L

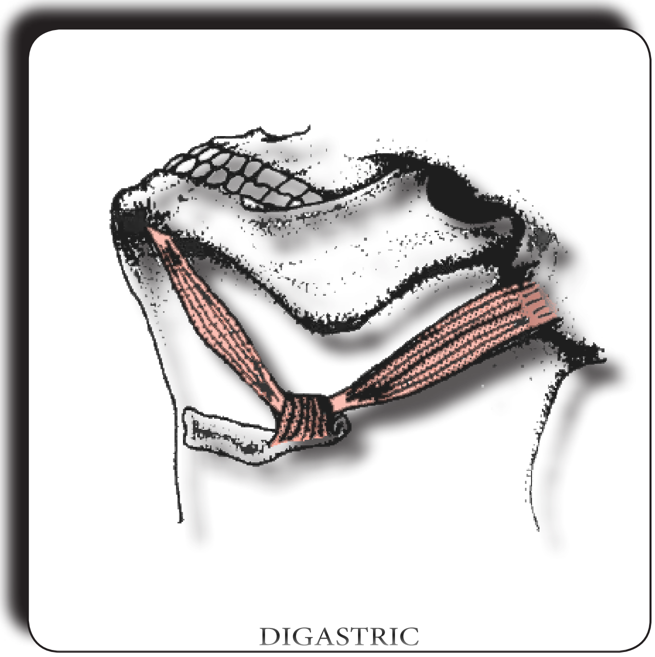
M. M. : C2

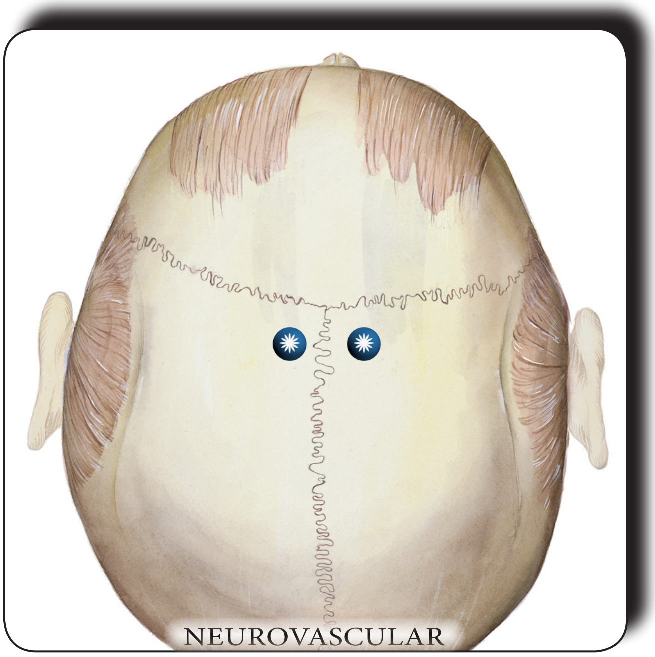
CRANIAL: Glabella

FOOT: 4th Metatarsal

NUTRIENT SOURCE: Vitamin E
1. Core Vitamin E (NW)




DIGASTRIC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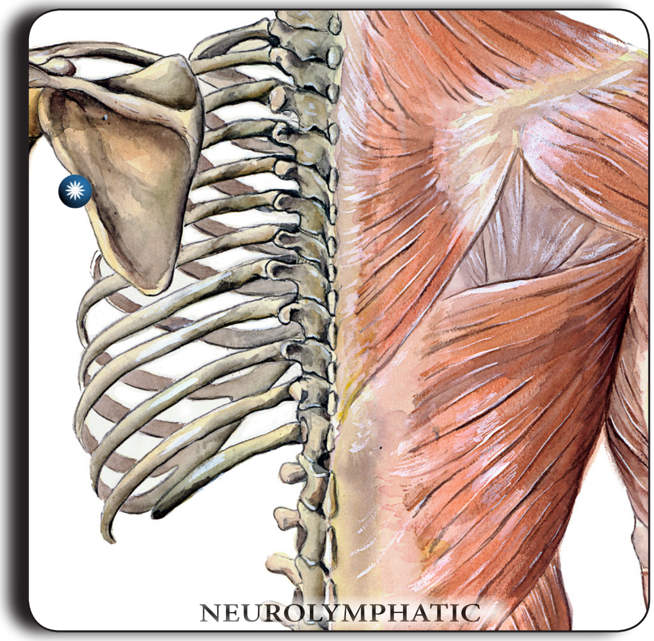
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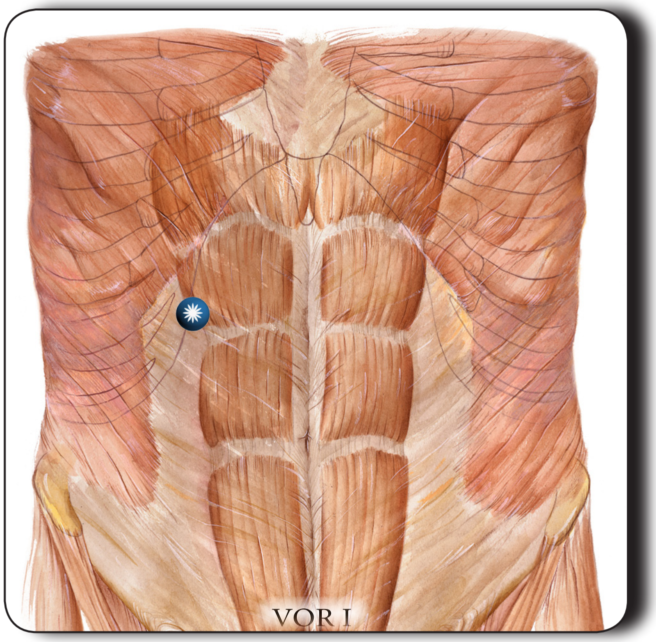
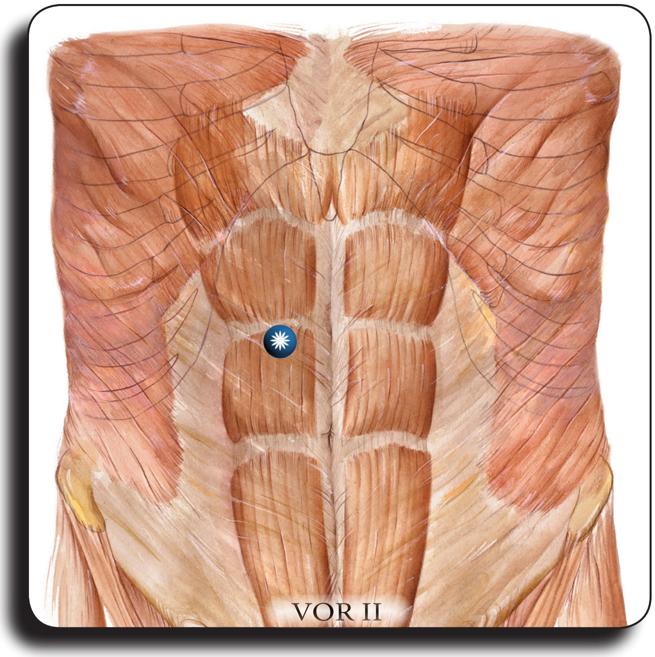

VOR I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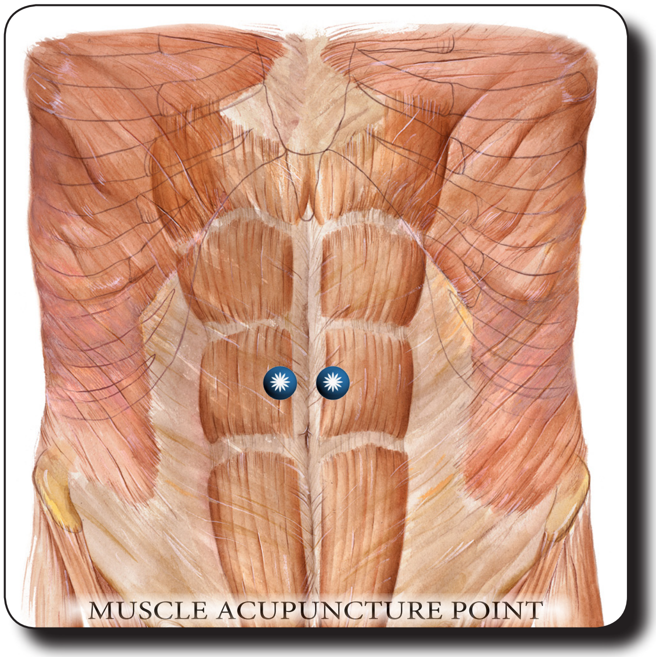

MUSCLE ACUPUNCTURE POINT

Muscle 292: DIGASTRIC, (Posterior Belly)

ORIGIN: Mastoid process of temporal bone.

INSERTION: Into a rounded tendon which is attached to the suprahyoid aponeurosis which is attached to the greater cornu of the hyoid.

ACTION: Raises and draws the hyoid backward assists in opening jaw and swallowing.

TEST:

TL Challenge: Touch belly of posterior division located superior to hyoid, inferior to mandible, anterior to SCM and just anterior and inferior to Atlas.

NEUROVASCULAR: (Sup/BL) Parietal bone, 1" posterior to anterior fontanel and 1/2" lateral to sagittal suture.

NEUROLYMPHATIC: (Post/L) 4th ICS, mid-axillary line.

VISCERAL ORGAN:

I. Gallbladder - Arteries: (Ant/R) 1/2" above origin lateral aspect of belly 3rd section Rectus Abdominus.

II. Stomach - Veins: (Ant/R) 2nd section Rectus Abdominus between K18 and St22.

M. A. P. : K16.8

V.L. : L4R

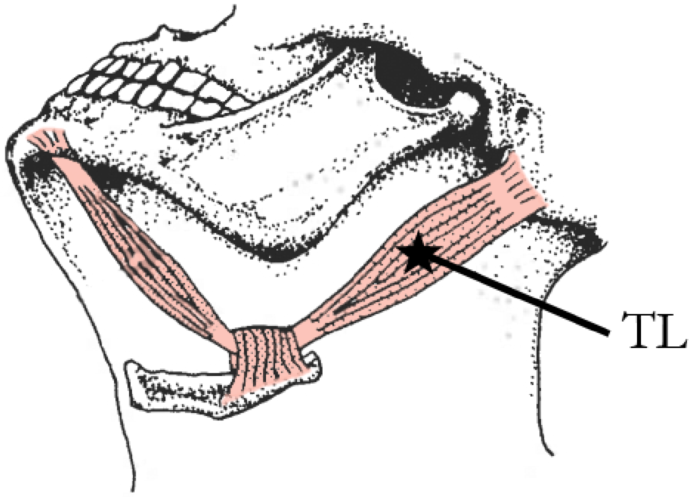
L. B. V.L. : C2R

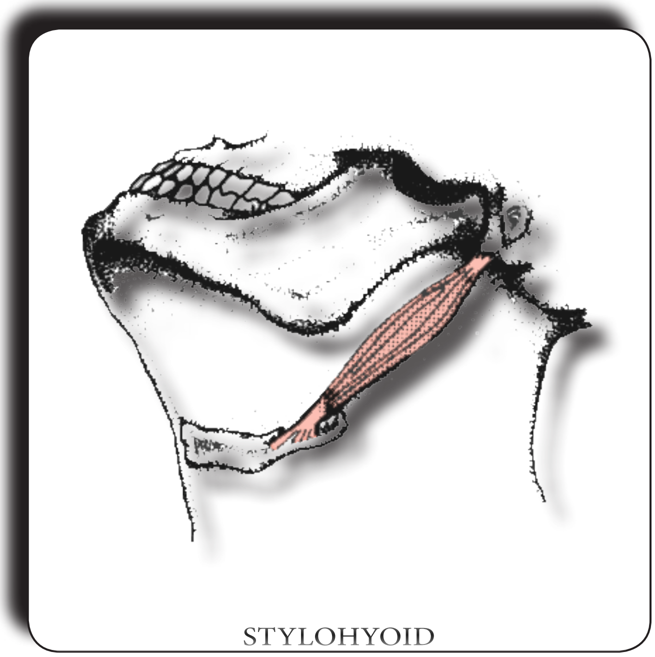
M. M. : C2

CRANIAL: Ethmoid

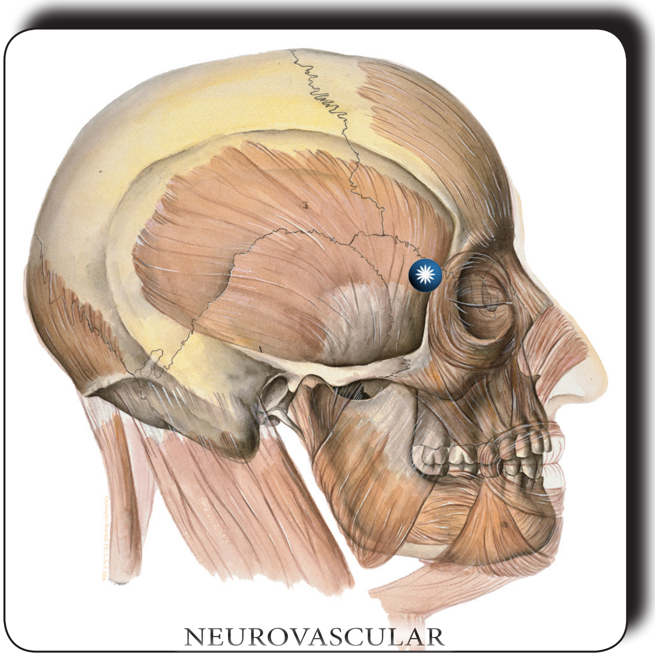
FOOT: 1st Cunieform

NUTRIENT SOURCE: Calcium-Bone Meal type
1. Core Calcium (NW)
2. Core Bone Matrix (NW)

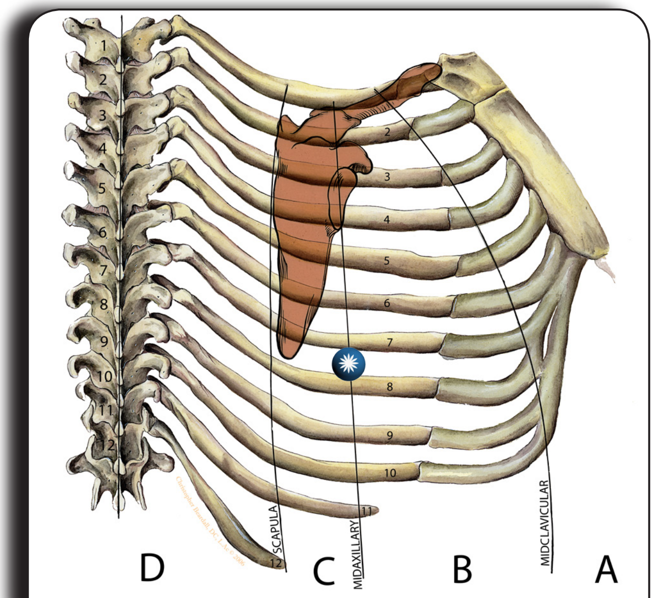




STYLOHYOID



NEUROVASCULAR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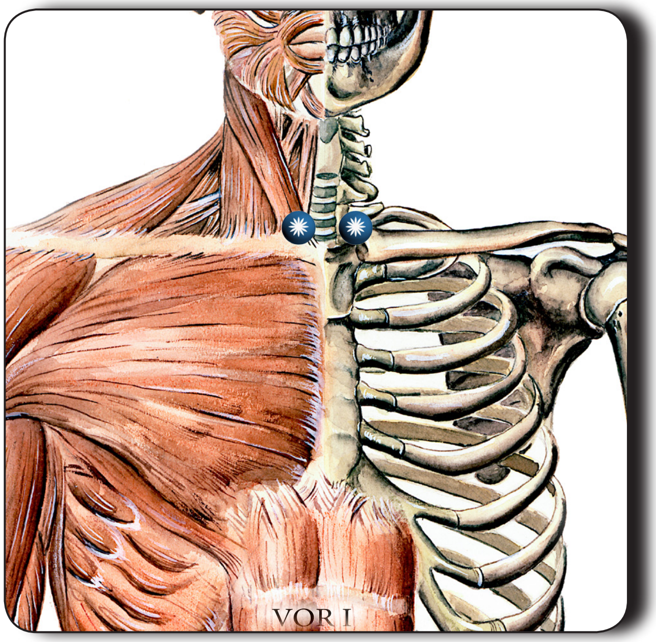
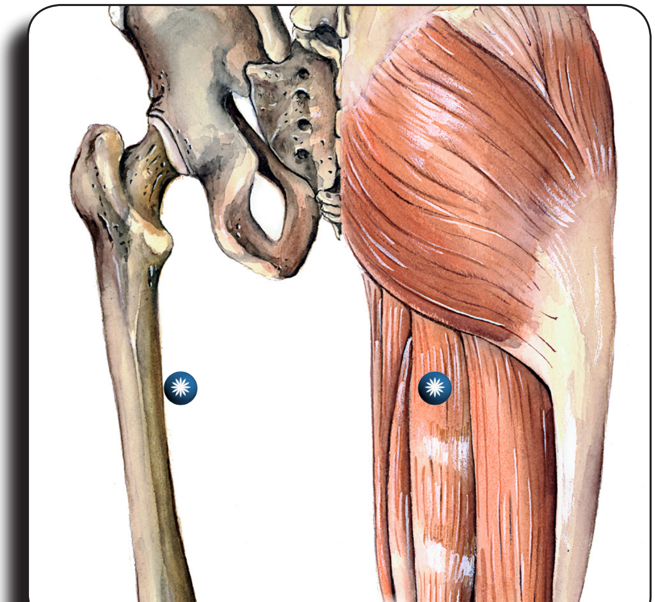
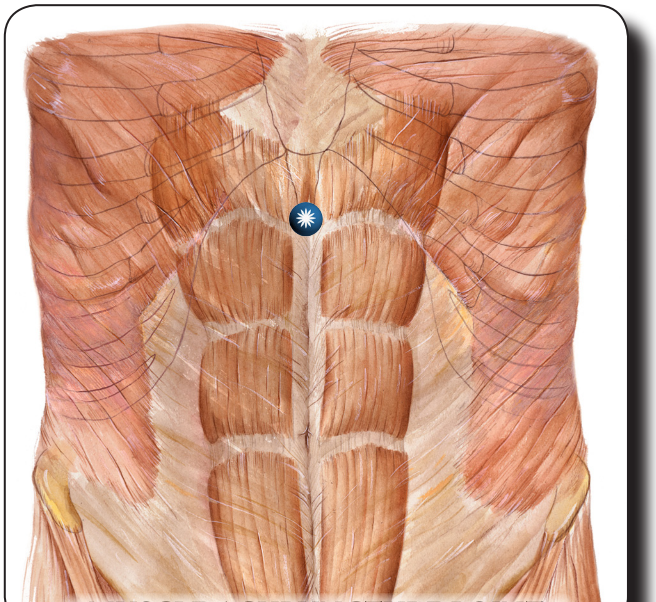
NEUROLYMPHATIC



VOR I



VOR II



MUSCLE ACUPUNCTURE POINT

Muscle 294: STYLOHYOID

ORIGIN: Posterior surface of the styloid process near its base.

INSERTION: Body of the hyoid bone.

ACTION: Draws hyoid and tongue upward.

TEST:

TL challenge: TL belly of muscle located superior to hyoid and anterior and inferior to the angle of the jaw.

NEUROVASCULAR: (Lat) Spheno-frontal suture at level of super-ciliary ridge.

NEUROLYMPHATIC: (Lat/R) 7th ICS, at the midaxillary line.

VISCERAL ORGAN:

I. *Thyroid:* (Ant/BL) 1" lateral to sternal notch on the lower medial aspect of the SCM.

II. *Ureter:* (Post/BL) Belly of semimembranosus 2" superior and 1" medial to B51.

M. A. P. : Cv15

V.L. : L5R

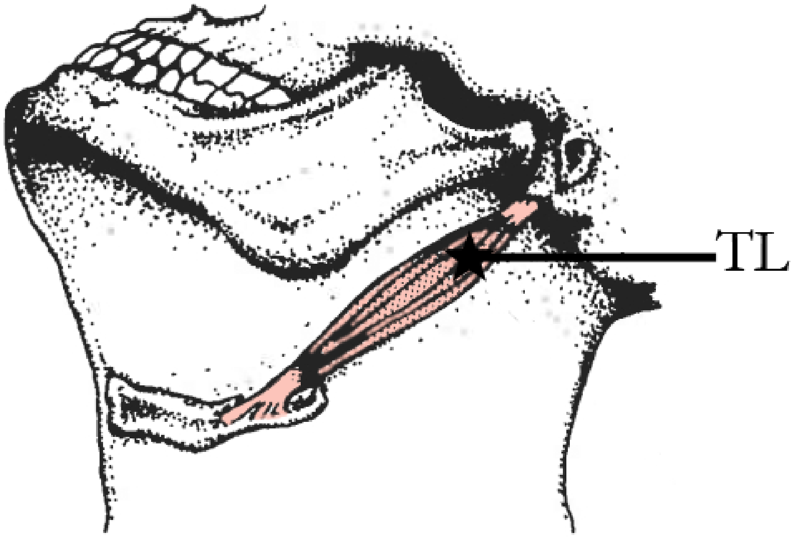
L. B. V.L. : C1R

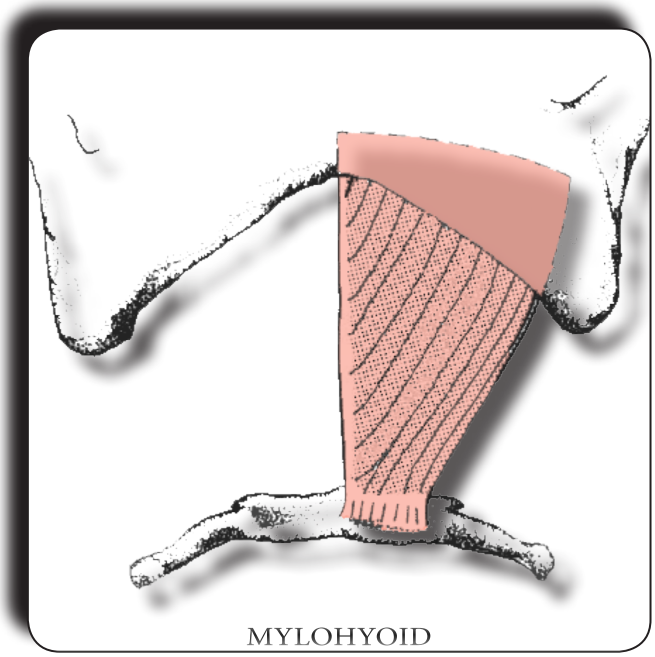
M. M. : C1

CRANIAL: Styloid

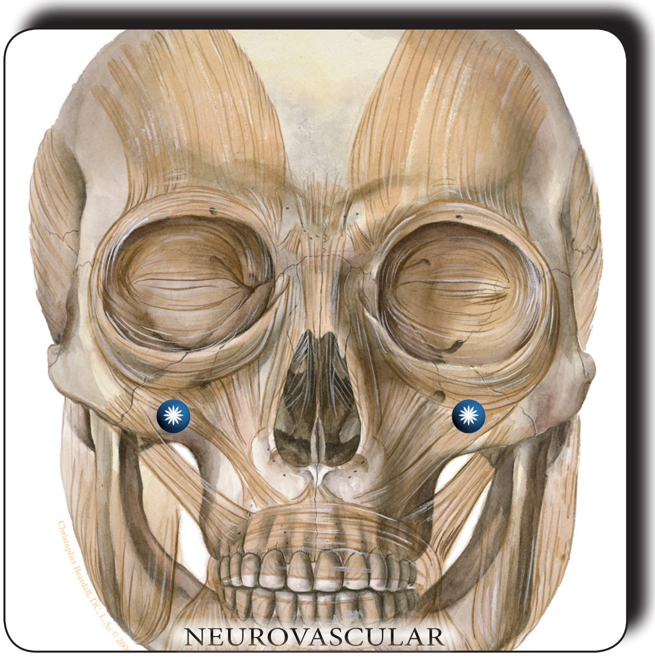
FOOT: Distal Phalanx-great toe

NUTRIENT SOURCE: Calcium Gluconate
1. Core Calcium (NW)
2. Core Bone Matrix (NW)
3. Calcium Gluconate (NW)

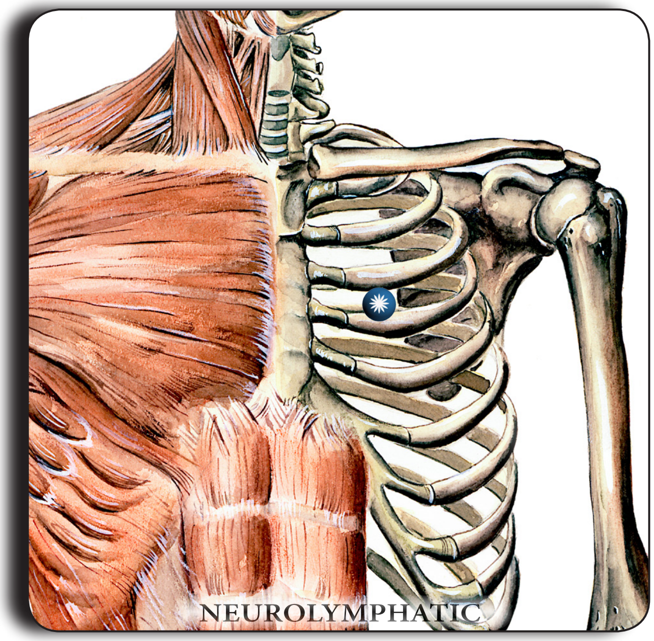




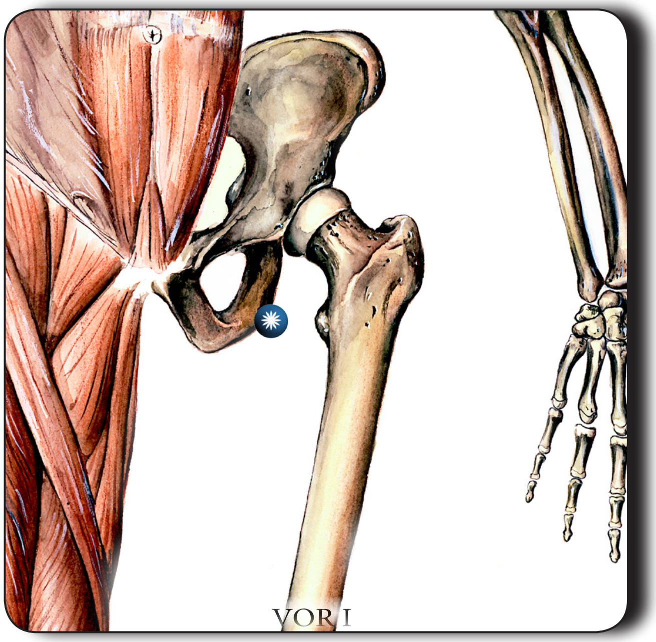
MYLOHYOID



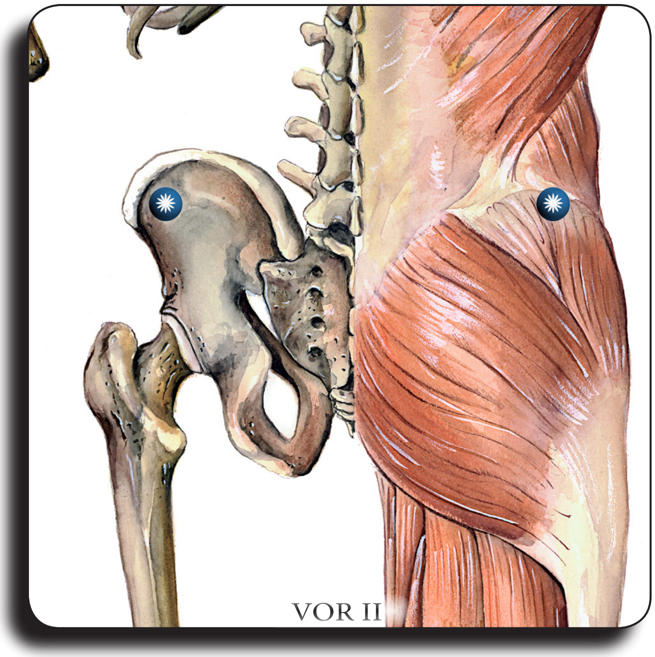
NEUROVASCULAR



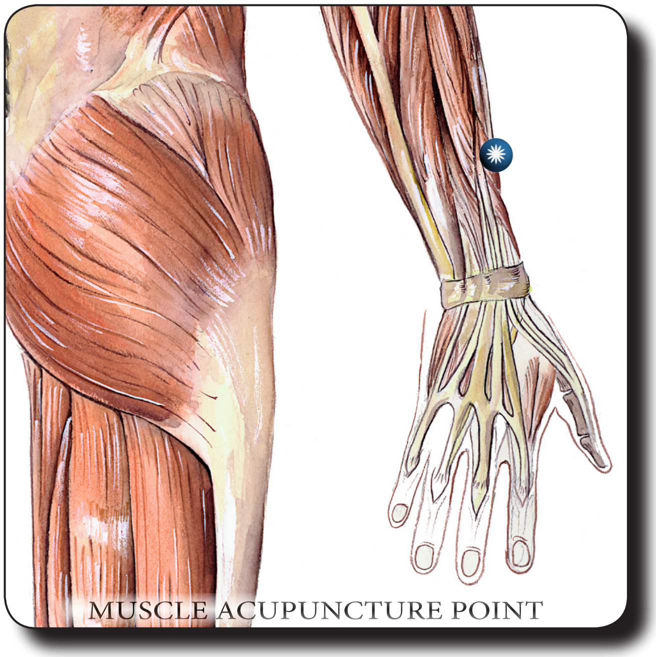
NEUROLYMPHATIC



VOR I



VOR II



MUSCLE ACUPUNCTURE POINT

Muscle 296: MYLOHYOID

ORIGIN: Muscular floor of the cavity of the mouth, mylohyoid line of the mandible.

INSERTION: Body of the hyoid.

ACTION: Raises the hyoid and the floor of the cavity of the mouth.

TEST:

TL challenge: TL belly of muscle located superior to hyoid and inferior to mandible; TL is best achieved by touching inferior to mandible halfway between symphysis and angle of jaw.

NEUROVASCULAR: (Ant/BL) Maxillary bone, 1" below center of eye.

NEUROLYMPHATIC: (Ant/L) 3rd ICS, 1-2" lateral to sternum.

VISCERAL ORGAN:

I. Bladder: (Ant/L) lateral to Lv11 on inferior ramus of ischium.

II. Tonsils: (Post/BL) near the crest of the ilium, origin of Gluteus Medius, Medial division.

M. A. P. : Li7

V.L. : T12R

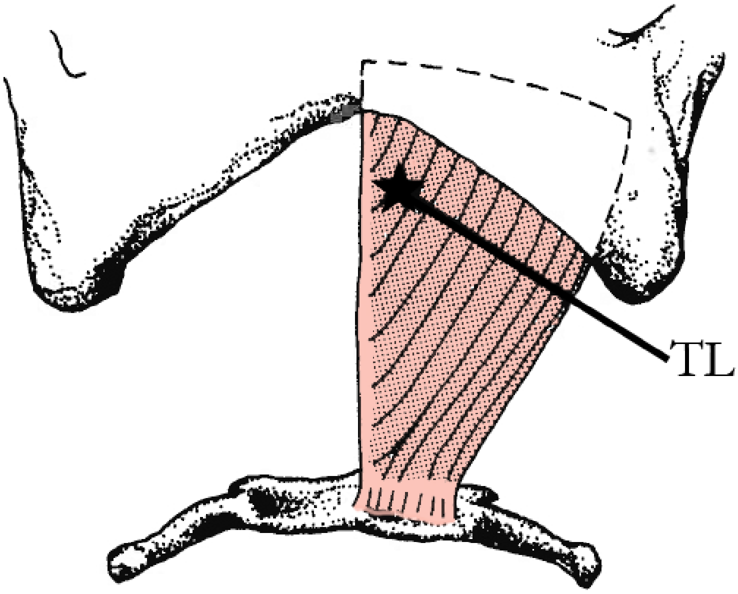
L. B. V.L. : C6R

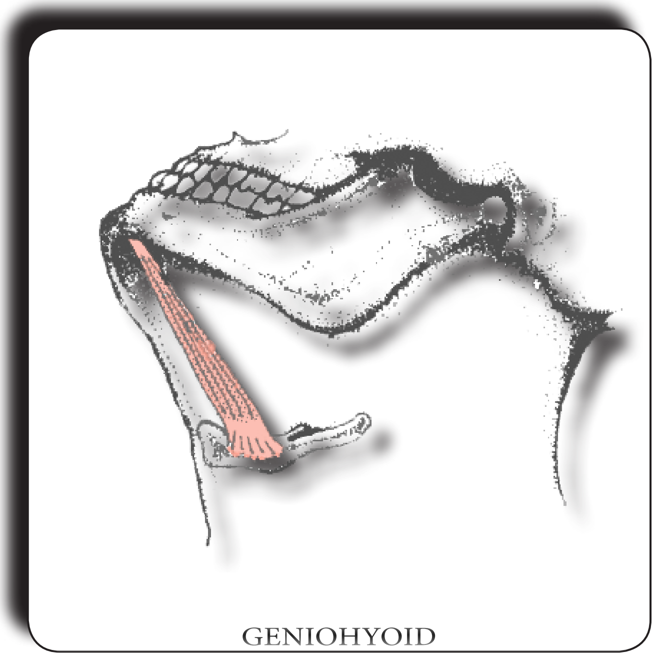
M. M. : C2

CRANIAL: Frontal

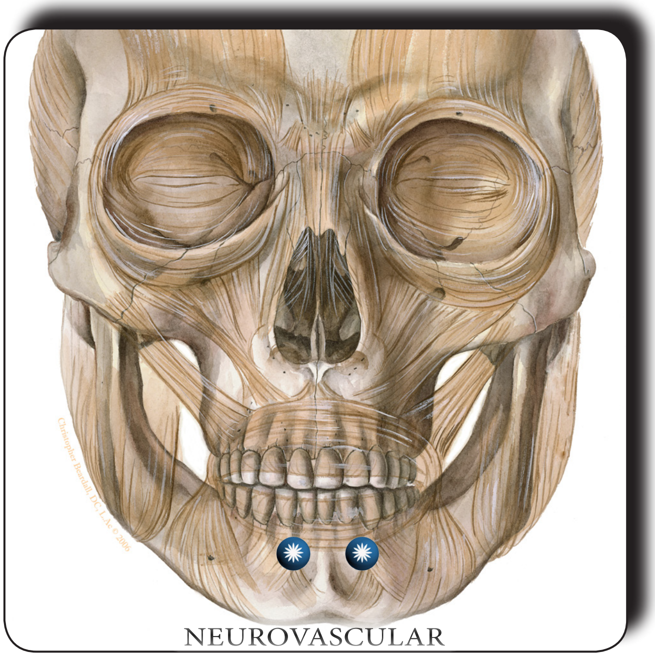
FOOT: Navicular

NUTRIENT SOURCE: B12
1. Core Health Reserve (NW)
2. B12 Lozenge (NW)
3. B-Complex (NW)





GENIOHYOID



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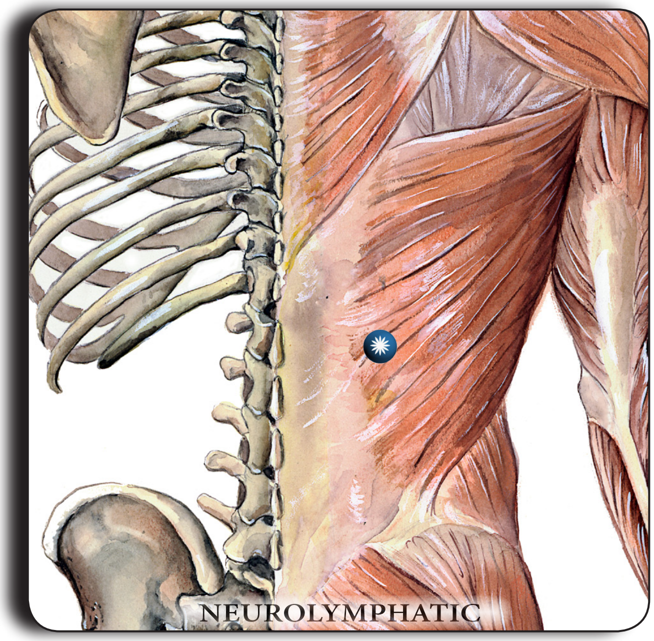
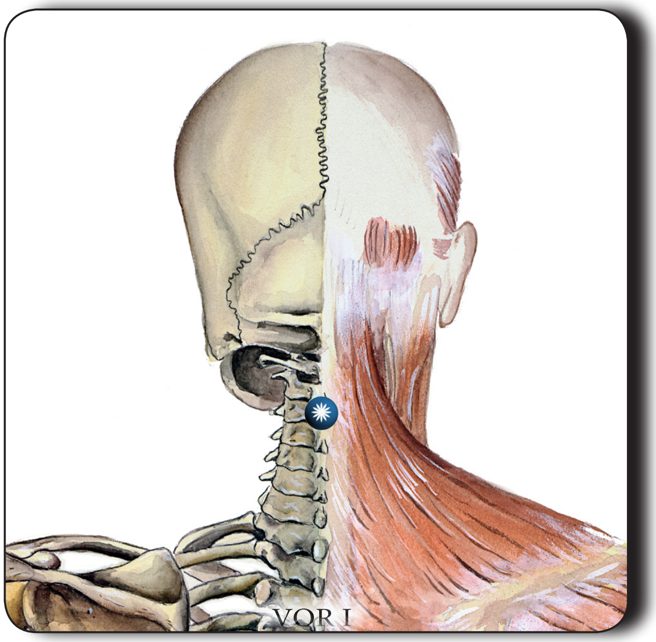
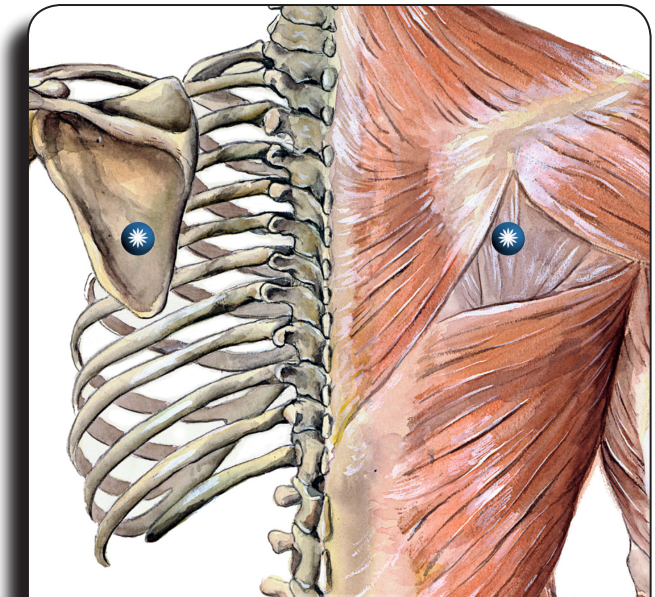


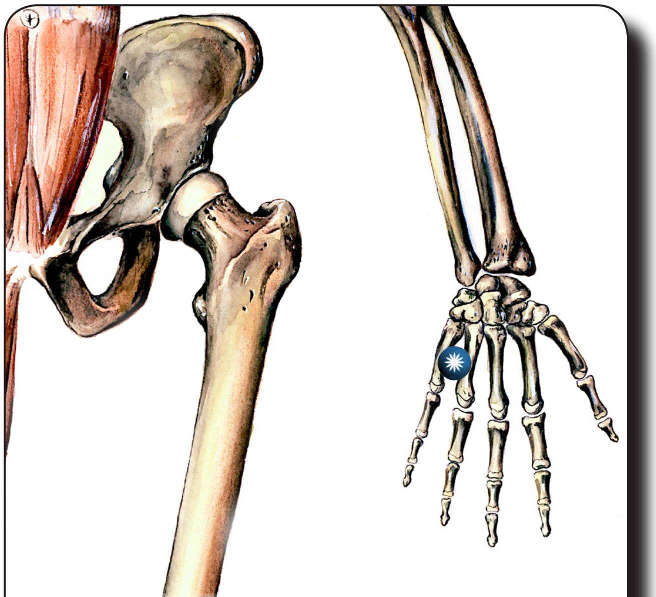
NEUROLYMPHATIC



VOR I



VOR II



MUSCLE ACUPUNCTURE POINT

Muscle 298: GENIOHYOID

ORIGIN: Inferior genial tubercle on back of symphysis of mandible.

INSERTION: Anterior surface of body of hyoid.

ACTION: Draws the hyoid bone and tongue forward.

TEST:

TL challenge: TL belly of muscle located just lateral to midline between hyoid and mandible.

NEUROVASCULAR: (Ant/BL) Mandible 1/2" lateral to pogonion.

NEUROLYMPHATIC: (Post/R) 12th ICS, 3" lateral to spine.

VISCERAL ORGAN:

I. *Thyroid:* (Post) Gv14.9 between 2nd and 3rd cervical spinous process.

II. *Eye:* (Post/BL) Scapula-medial to Si11, middle of scapula.

M. A. P. : H7.6

V.L. : T9R

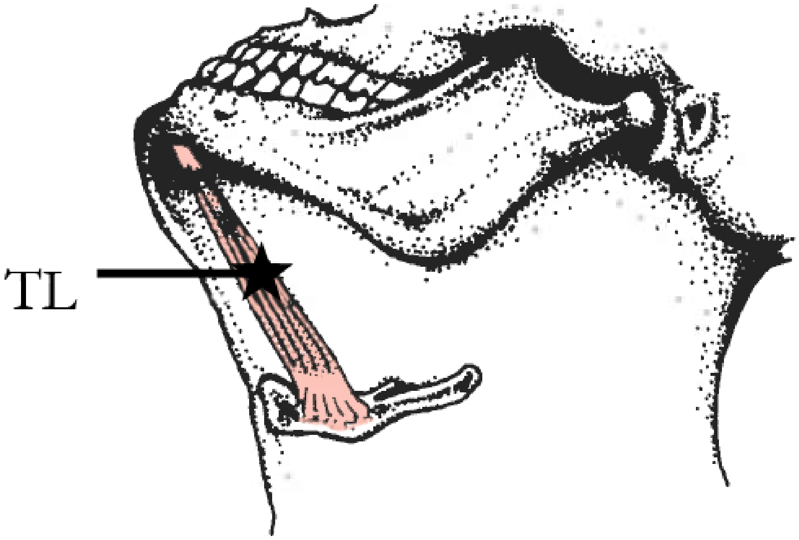
L. B. V.L. : T2R

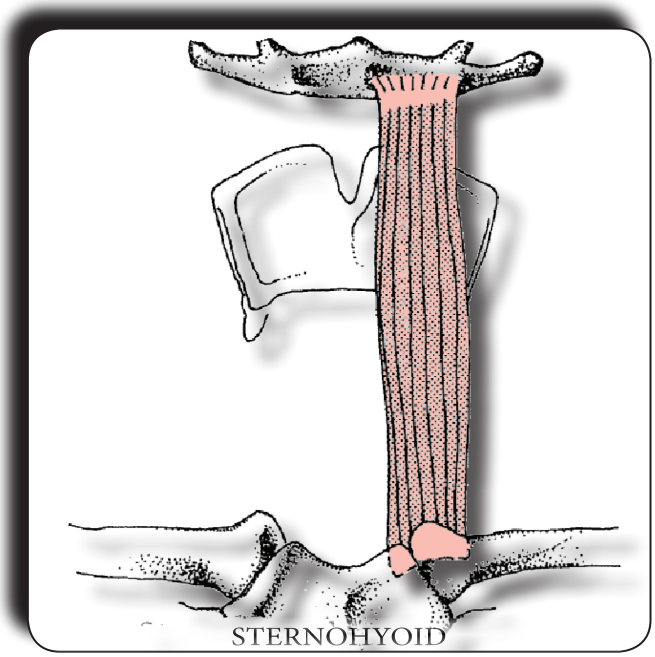
M. M. : C2

CRANIAL: Lacrimal

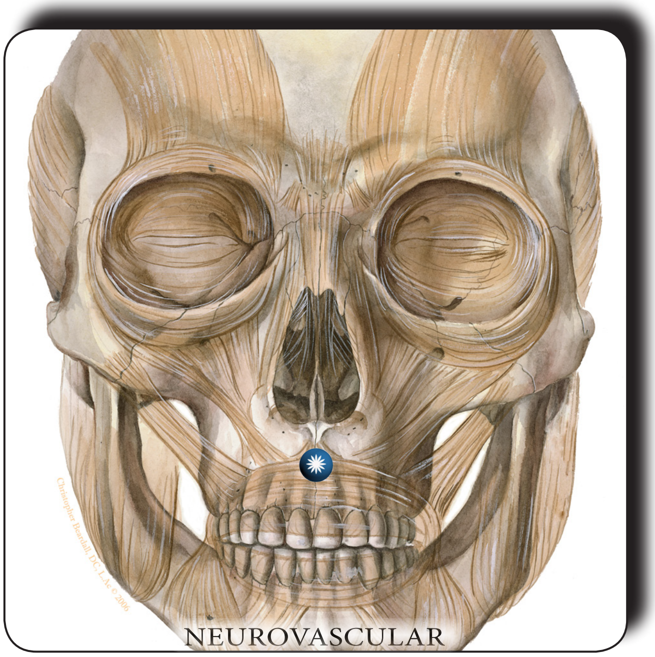
FOOT: 2nd Metatarsal, Proximal Phalanx

NUTRIENT SOURCE: Iridium
1. Core Level Bile

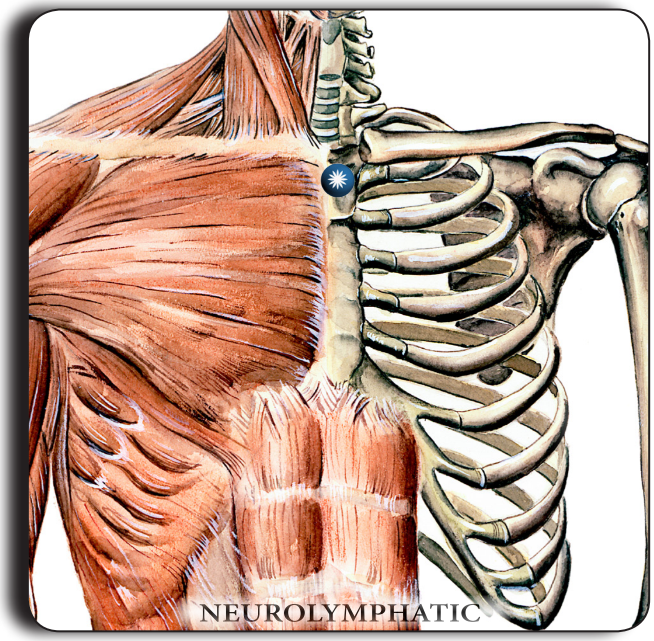




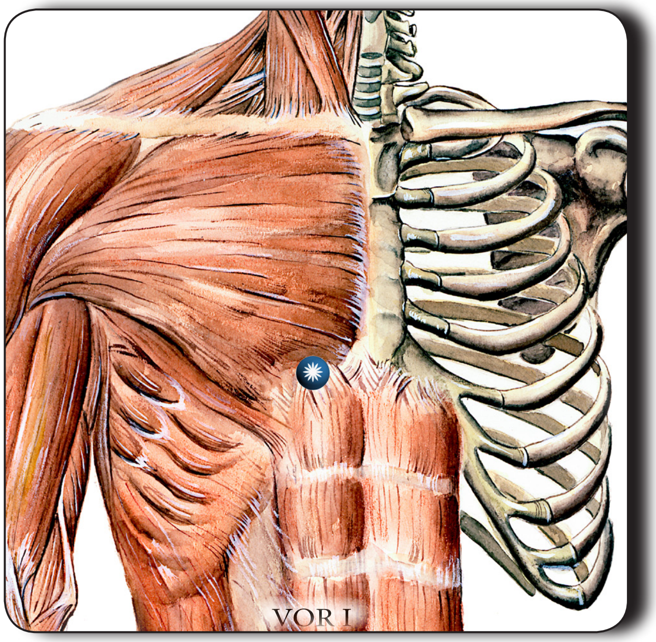
STERNOHYOID



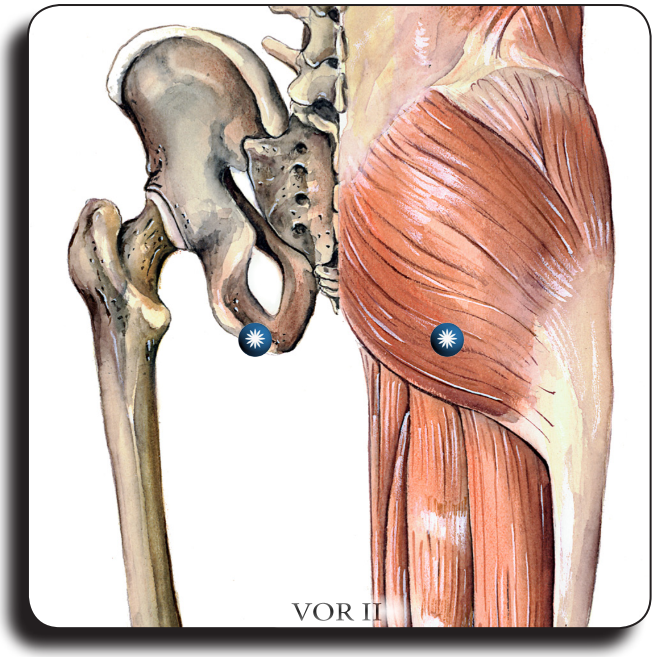
NEUROVASCULAR



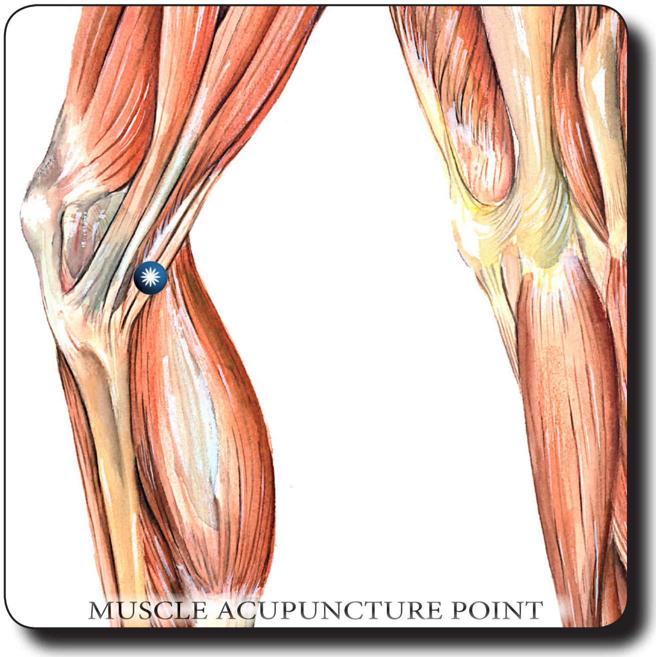
NEUROLYMPHATIC



VOR I



VOR II



MUSCLE ACUPUNCTURE POINT

Muscle 300: STERNOHYOID

ORIGIN: Posterior surface of the medial end of the clavicle, posterior sternoclavicular ligament and upper posterior part of the manubrium.

INSERTION: Lower border of the body of the hyoid bone.

ACTION: Draws the hyoid bone downward.

TEST:

TL challenge: TL belly of muscle located medial to SCM, below thyroid cartilage and superior to clavicle.

NEUROVASCULAR: (Ant/Midline) halfway between upper lip and base of nose.

NEUROLYMPHATIC: (Ant/Midline) of sternum halfway between angle of Louis and sternal notch.

VISCERAL ORGAN:

I. Hepatic Duct: (Ant/R) costocartilage of 6th rib 1" lateral to midline.

II. Prostate/Uterus: (Post/BL) origin of hamstrings at the ischium.

M. A. P. : Li8

V.L. : T2R

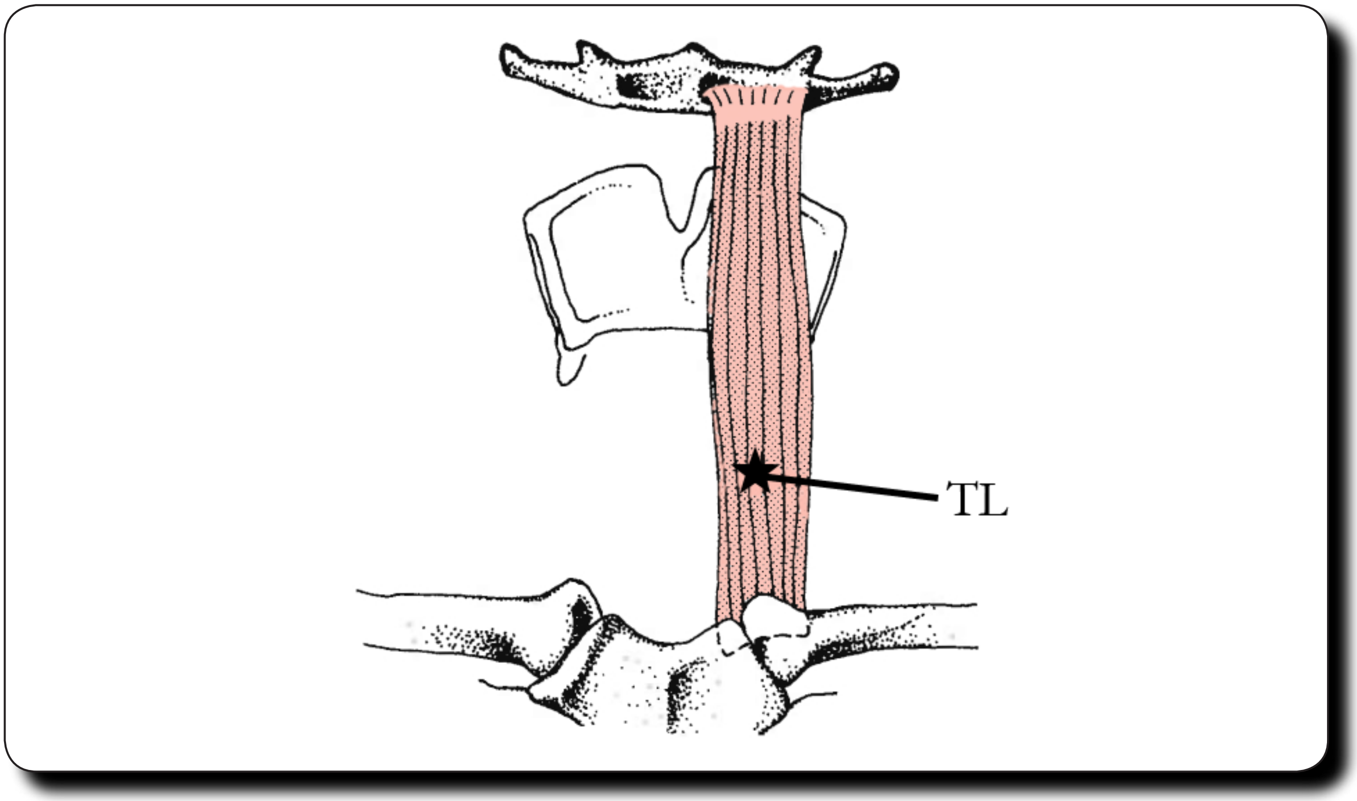
L. B. V.L. : T9R

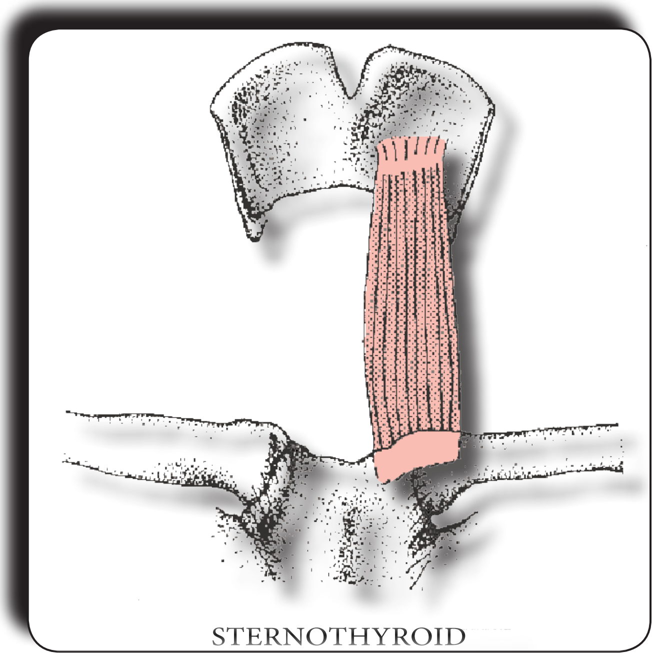
M. M. : C3

CRANIAL: Internal Temporal

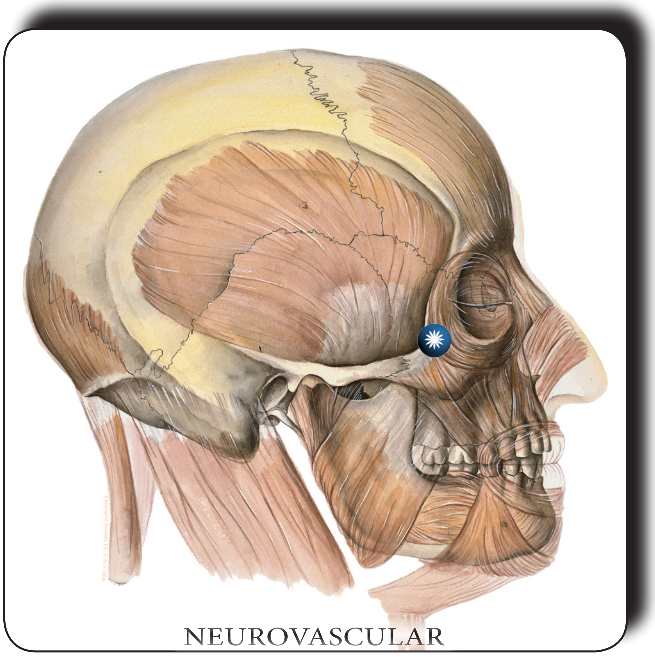
FOOT: Cuboid

NUTRIENT SOURCE: Pantothenic Acid (B5)
1.Core Health Reserve (NW)
2. B-Complex
3. Pantothenic Acid (NW)

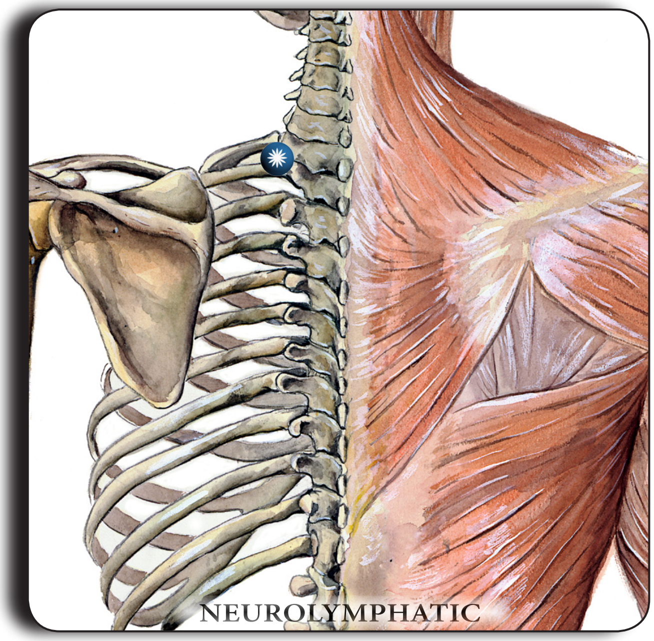




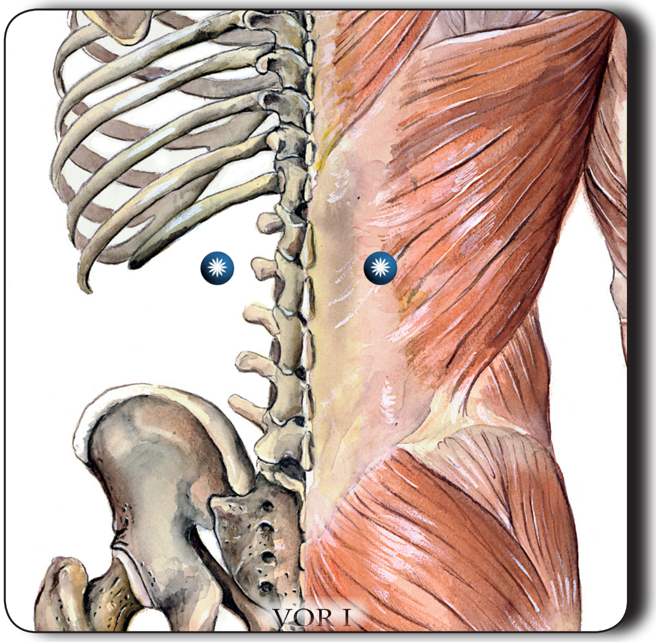
STERNOTHYROID



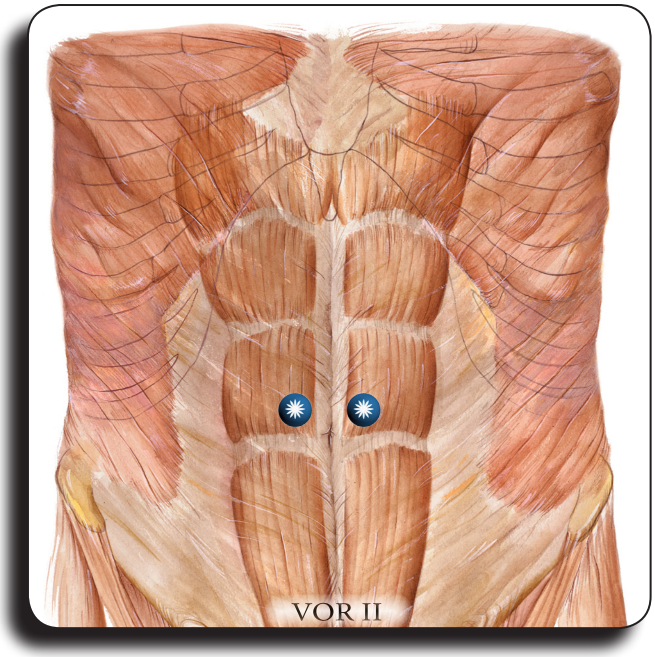
NEUROVASCULAR



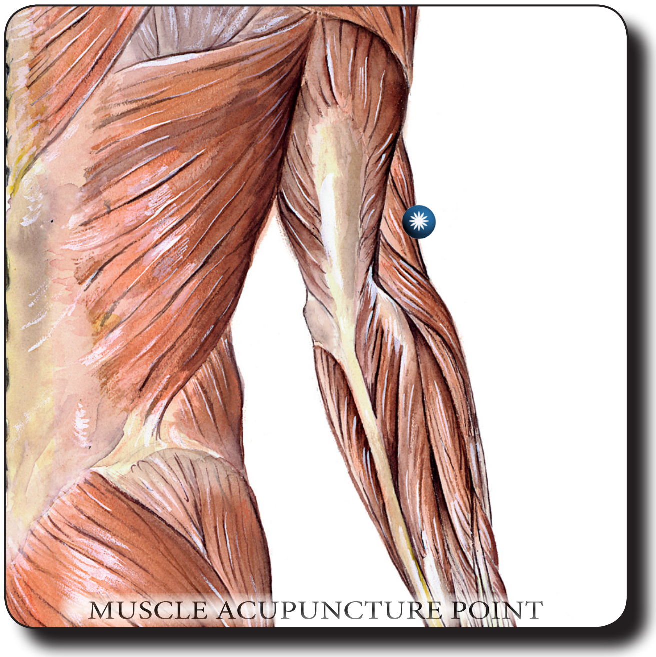
NEUROLYMPHATIC



VOR I



VOR II



MUSCLE ACUPUNCTURE POINT

Muscle 302: STERNOTHYROID

ORIGIN: Posterior surface of manubrium sterni and the edge of the cartilage of the 1st rib and sometimes 2nd rib.

INSERTION: Oblique line on the lamina of the thyroid cartilage.

ACTION: Draws the thyroid cartilage downward.

TEST:

TL challenge: TL belly of muscle located medial to SCM at its sternal origin just superior to clavicle.

NEUROVASCULAR: (Lat) Zygomatic bone at the level of the eye.

NEUROLYMPHATIC: (Post/L) 1st ICS, at the spine.

VISCERAL ORGAN:

I. Kidney: (Post/BL) 1" lateral to the spine at the level of 2nd lumbar.

II. Adrenals: (Ant/BL) 1/2" lateral and superior to umbilicus in 2nd section of Rectus Abdominus

M. A. P. : Li13.3

V.L. : T3L

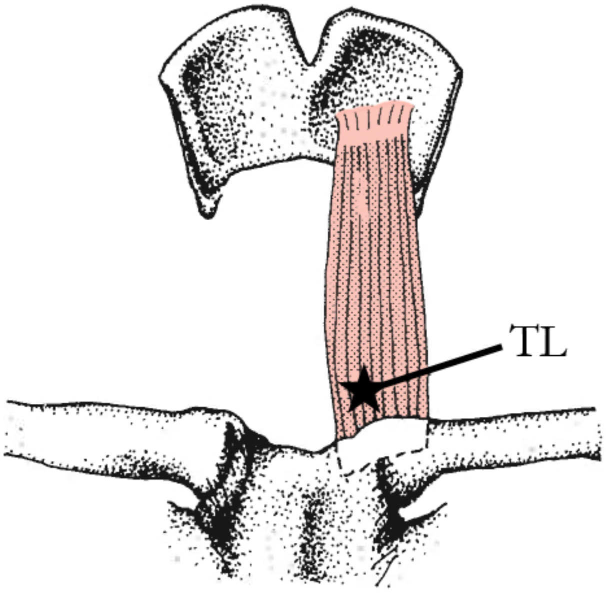
L. B. V.L. : T8L

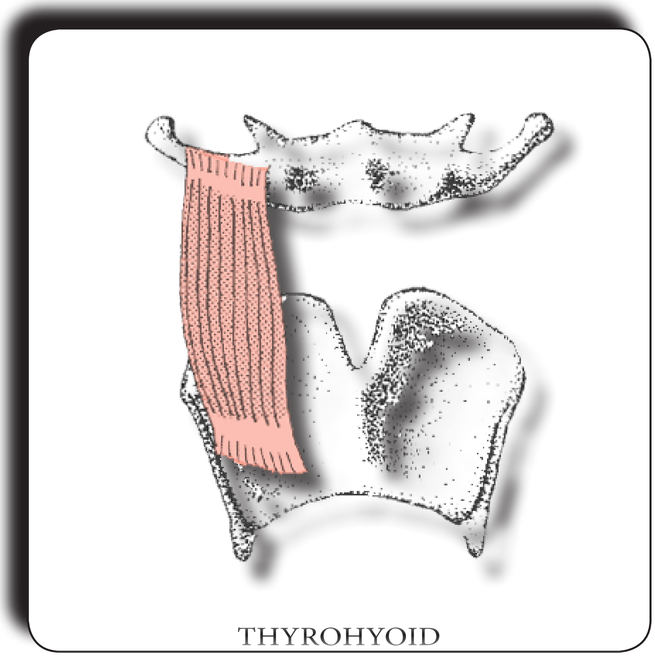
M. M. : C3

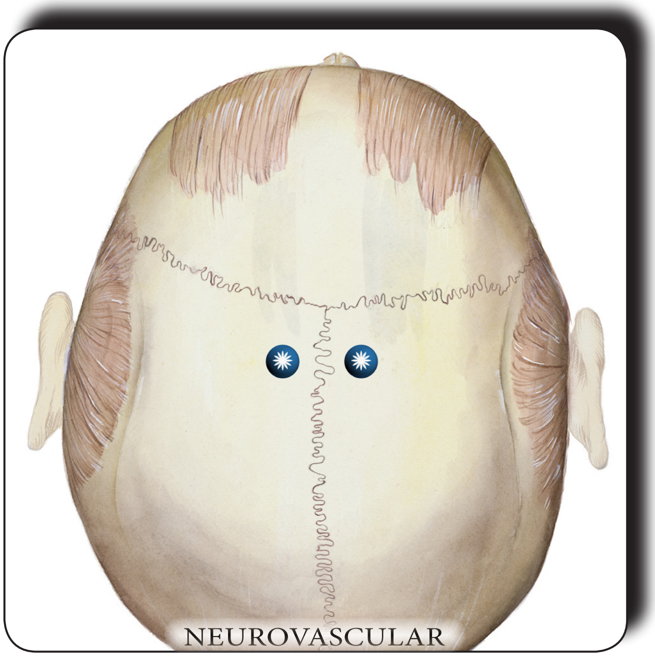
CRANIAL: Sphenoid

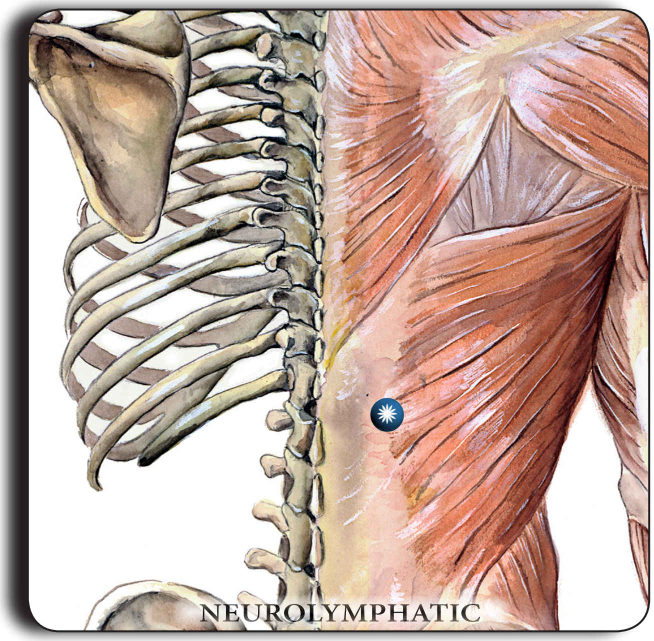
FOOT: 3rd Cunieform

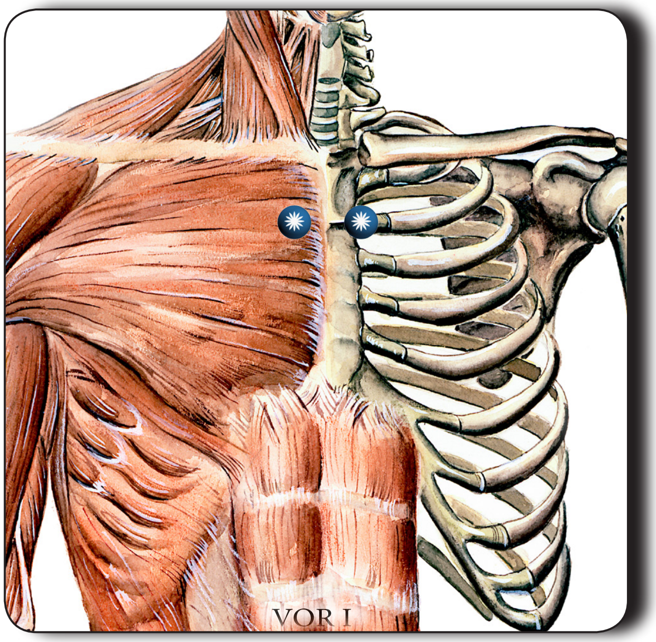
NUTRIENT SOURCE: Calcium Lactate
1. Core Calcium (NW)
2. Core Bone Matrix (NW)

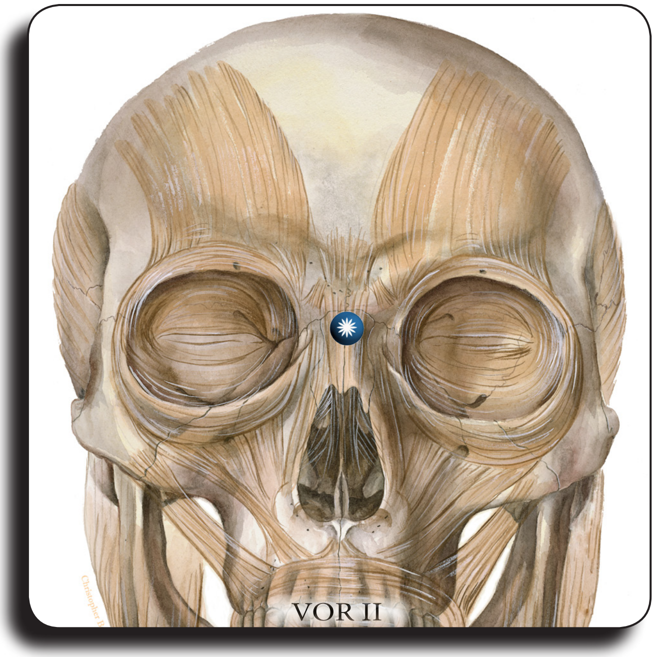


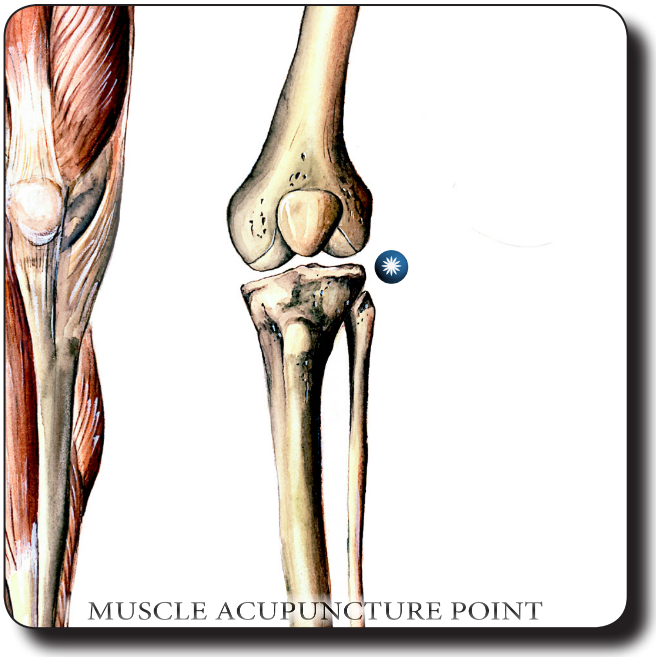

THYROHYOID


NEUROVASCULAR


NEUROLYMPHATIC


VOR I


VOR II


MUSCLE ACUPUNCTURE POINT

Muscle 304: THYROHYOID

ORIGIN: Oblique line of lamina of the thyroid cartilage.

INSERTION: Lower border of the greater cornu of the hyoid bone.

ACTION: Draws the hyoid bone downward or if the latter is fixed draws the thyroid cartilage upward.

TEST:

TL challenge: TL belly of muscle located on thyroid cartilage. Push the belly of sternohyoid laterally as this muscle is located behind it.

NEUROVASCULAR: (Sup/BL) Parietal bone, superior anterior section, 1/2" lateral to sagittal suture and 1" posterior to coronal suture.

NEUROLYMPHATIC: (Post/R) 12th ICS, 1-2" lateral to spine.

VISCERAL ORGAN:

I. *Thymus:* (Ant/BL) on sternum, 1/2" lateral, to midline at level of 2nd rib (Cv 20).

II. *Nose:* (Ant) Gv24.6 at level of eyes midline.

M. A. P. : G33.0

V.L. : L3L

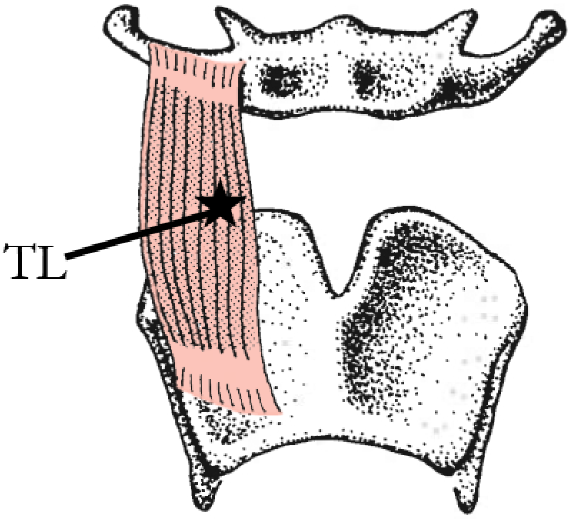
L. B. V.L. : C3L

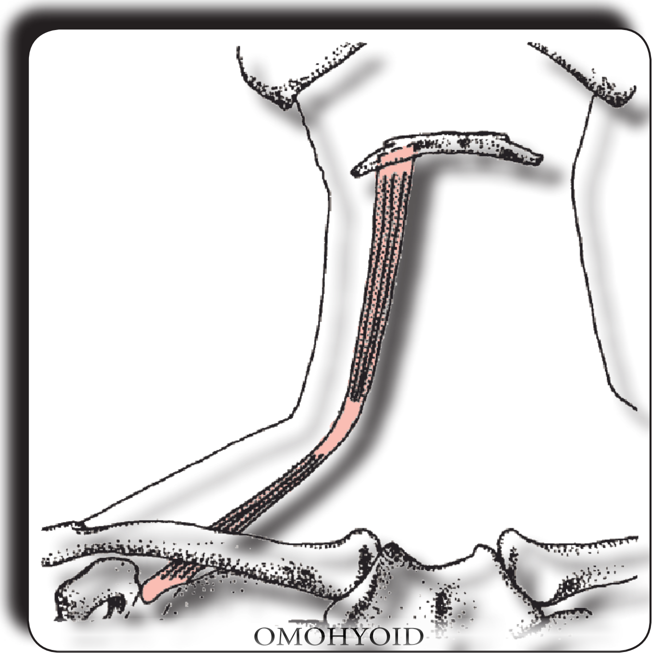
M. M. : C3

CRANIAL: Zygomatic

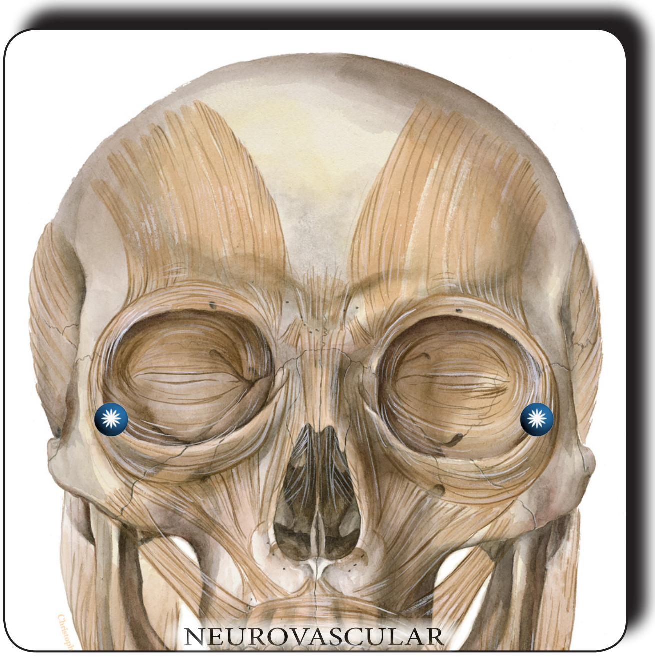
FOOT: 3rd Cunieform

NUTRIENT SOURCE: Manganese
1. Core Manganese (NW)

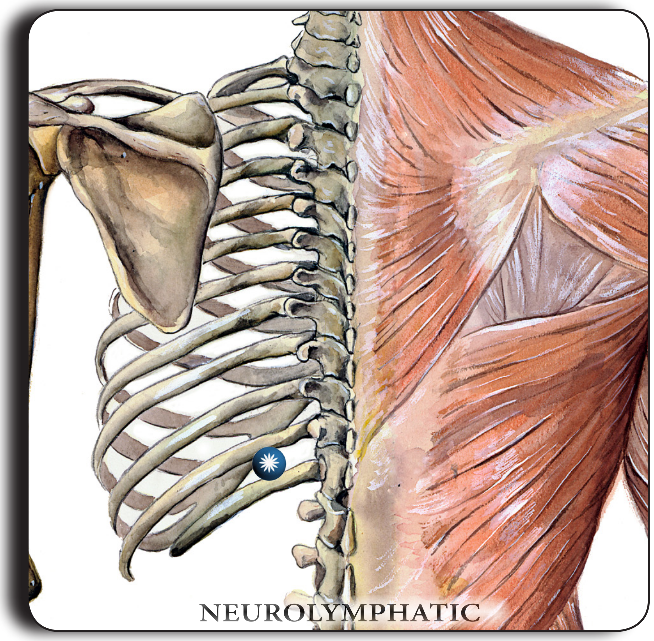




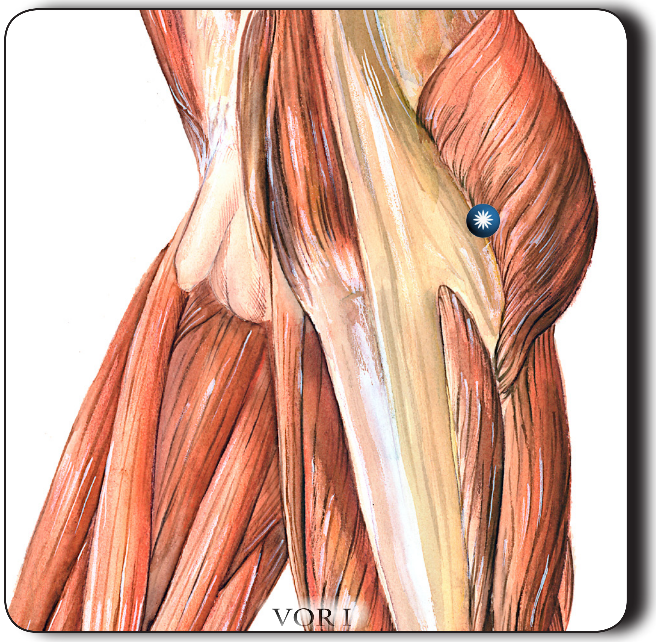
OMOHYOID



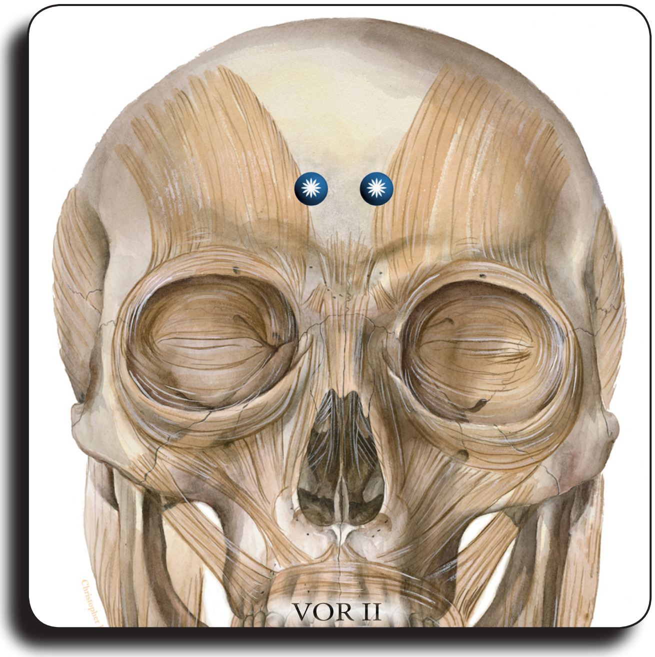
NEUROVASCULAR



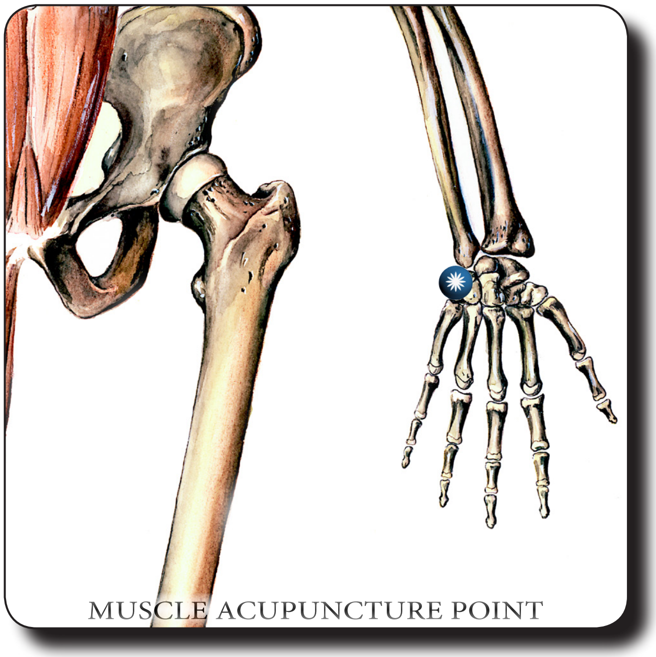
NEUROLYMPHATIC



VOR I



VOR II



MUSCLE ACUPUNCTURE POINT

Muscle 306: OMOHYOID

ORIGIN: Upper border of scapula.

INSERTION: Lower border of hyoid.

ACTION: Draws shoulders forward and superior as far as possible.

TEST:

Muscle challenge: Draw shoulders forward and superior as far as possible.

TL Challenge: TL belly of muscle located posterior to SCM, superior to clavicle and anterior to Trapezius.

NEUROVASCULAR: (Ant/BL) Zygomatic bone, lateral inferior aspect, eye orbit.

NEUROLYMPHATIC: (Post/L) 11th ICS, 2" lateral to spine.

VISCERAL ORGAN:

I. Spleen: (Post/BL) Pelvis, posterior lateral aspect, 2-3" superior to G30.

II. Eye: (Ant/BL) Frontal bone, superior to glabella, B2.5.

M. A. P. : H6.5

V.L. : L3R

L. B. V.L. : C3R

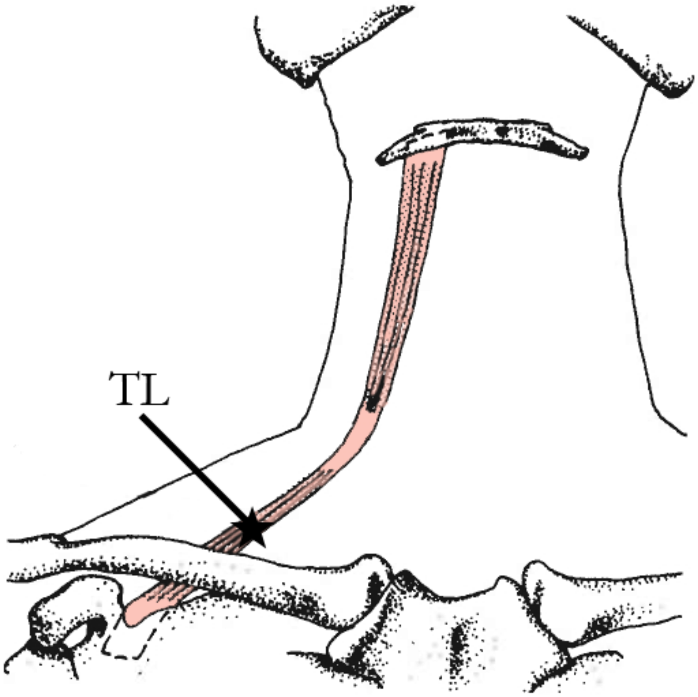
M. M. : C3

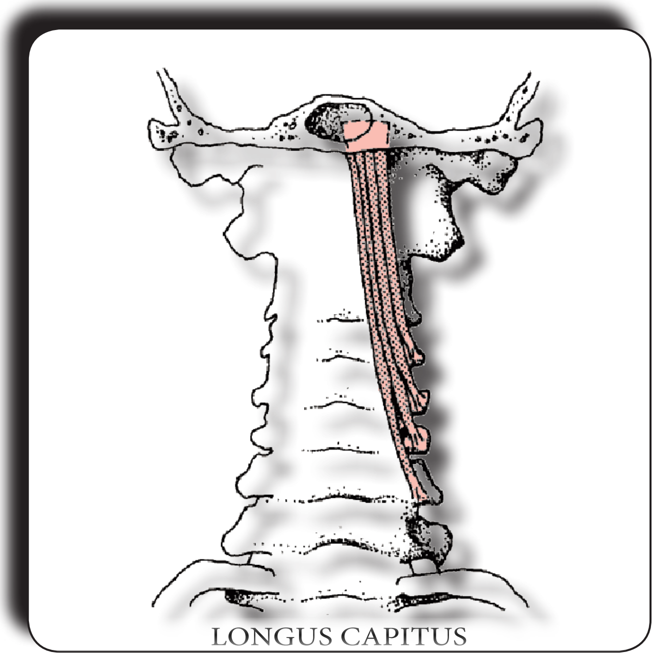
CRANIAL: Temporal

FOOT: Cuboid

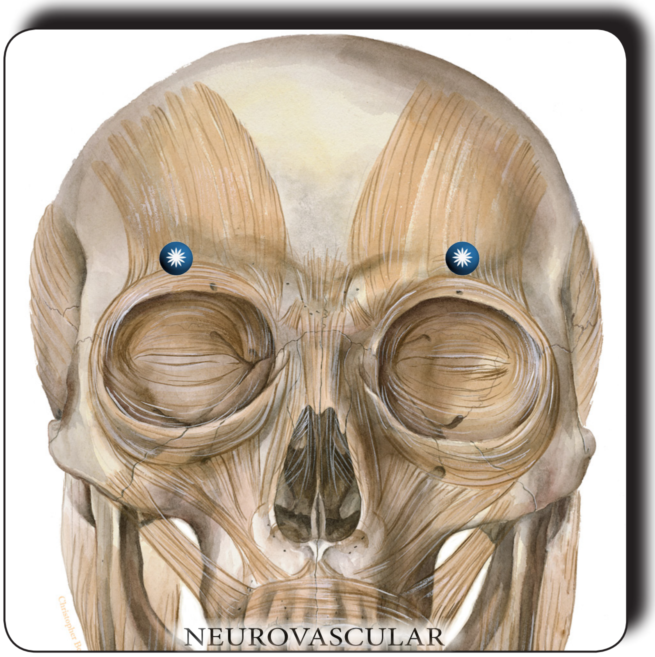
NUTRIENT SOURCE: Folic Acid and B12

1. Core B12 (NW)
2. Core Folic Acid (NW)
3. B-Complex (NW)

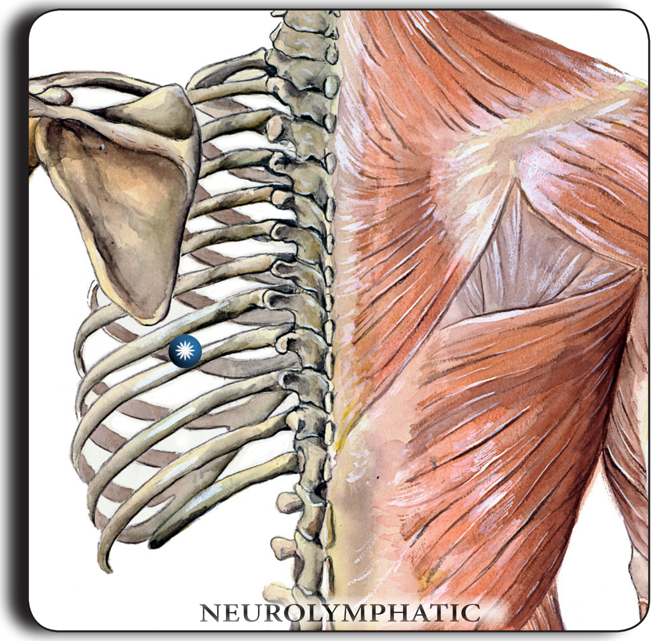




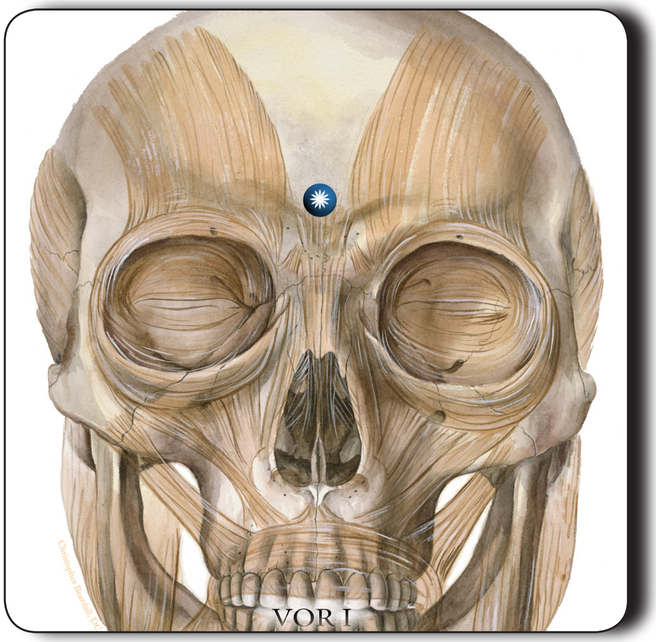
LONGUS CAPITUS



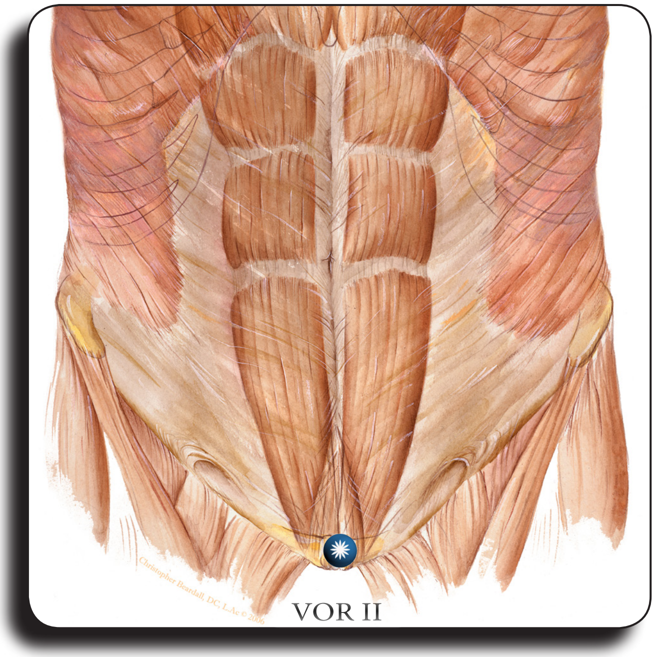
NEUROVASCULAR



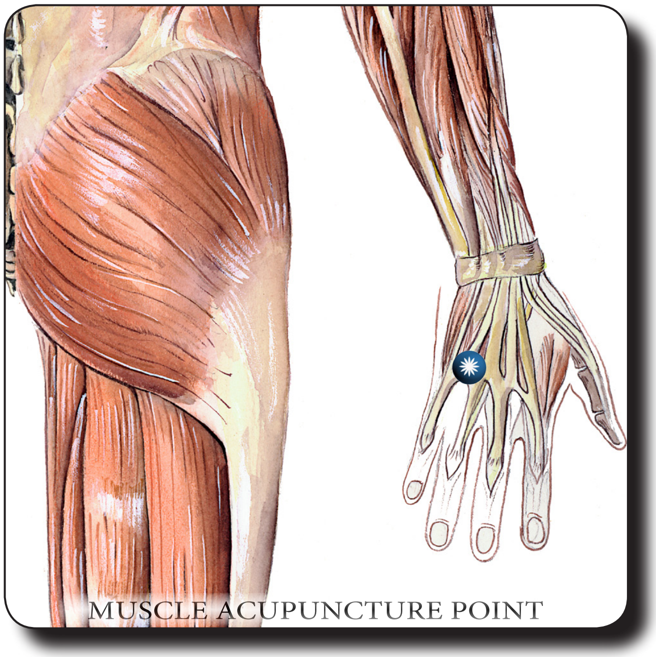
NEUROLYMPHATIC



VOR I



VOR II



MUSCLE ACUPUNCTURE POINT

Muscle 314: LONGUS CAPITUS

ORIGIN: By tendonitis slips from the anterior tubercles of the transverse processes of 3rd, 4th, 5th and 6th cervical vertebrae.

INSERTION: Inferior surface of the basilar part of the occiput.

ACTION: Flexes the head. "Yes" muscle of the neck.

TEST:

Patient: Supine. Flex neck on trunk 45°. Rotate head 10-20° away from side being tested. Flex head on neck.

Doctor: Brace contralateral shoulder. With lateral aspect of hand on maxillary and frontal bones extend head on neck, through sagittal plane.

NEUROVASCULAR: (Ant/BL) Frontal bone, directly superior over midline of eye and the supra-ciliary ridge.

NEUROLYMPHATIC: (Post/L) 8th ICS, at vertebral border of scapula.

VISCERAL ORGAN:

I. Anterior Pituitary: (Ant/Midline) Gv24.5 glabella.

II. Prostate/Uterus: (Ant/Midline) Cv2.2 just superior to Pubes.

M. A. P. : Tw3.2

V.L. : T6L

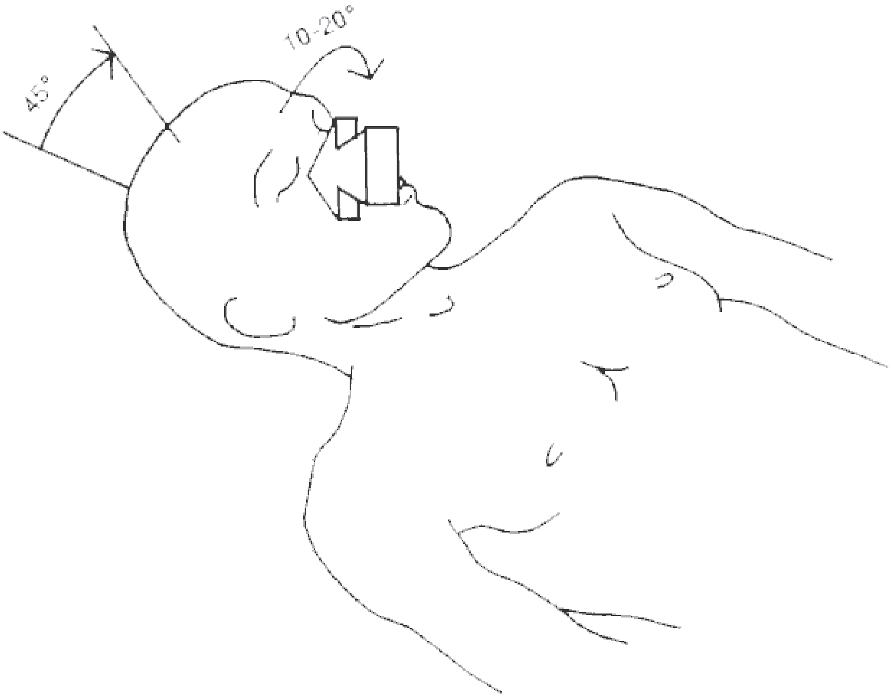
L. B. V.L. : T5L

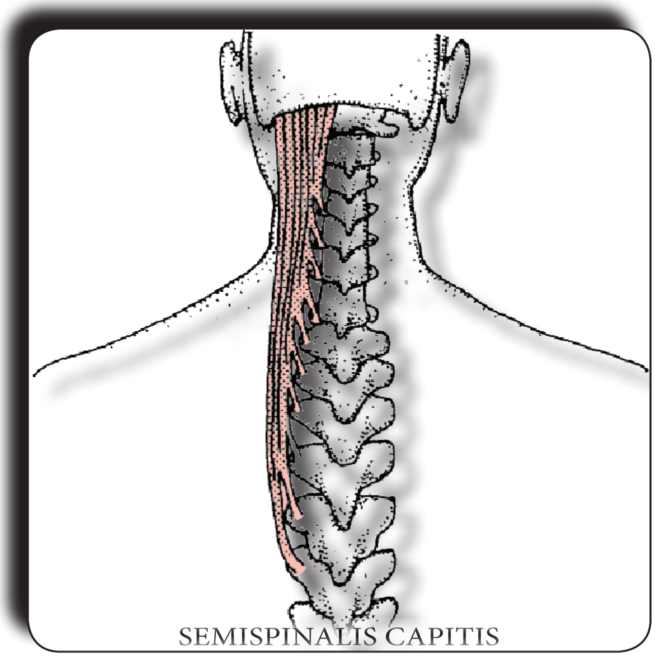
M. M. : C1

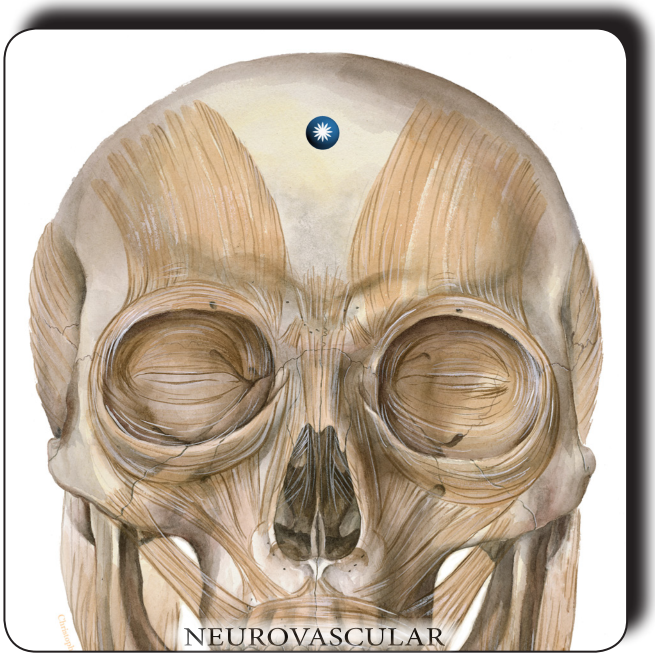
CRANIAL: Temporal, external rotation

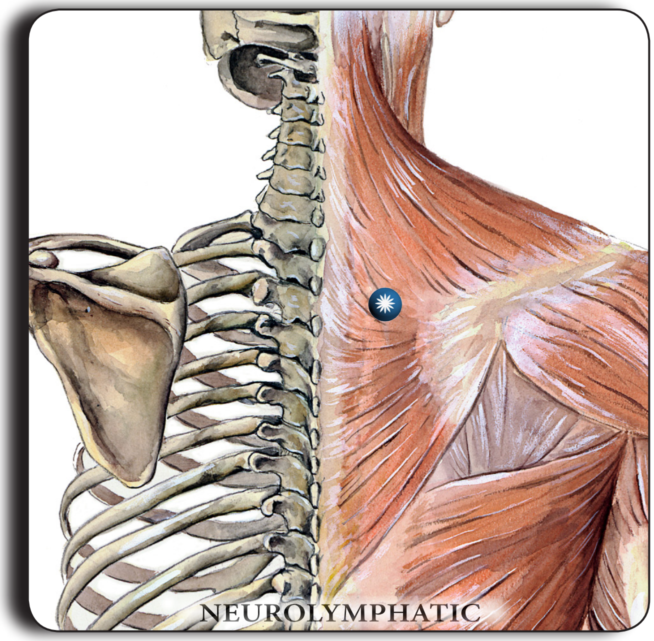
FOOT: Cuboid

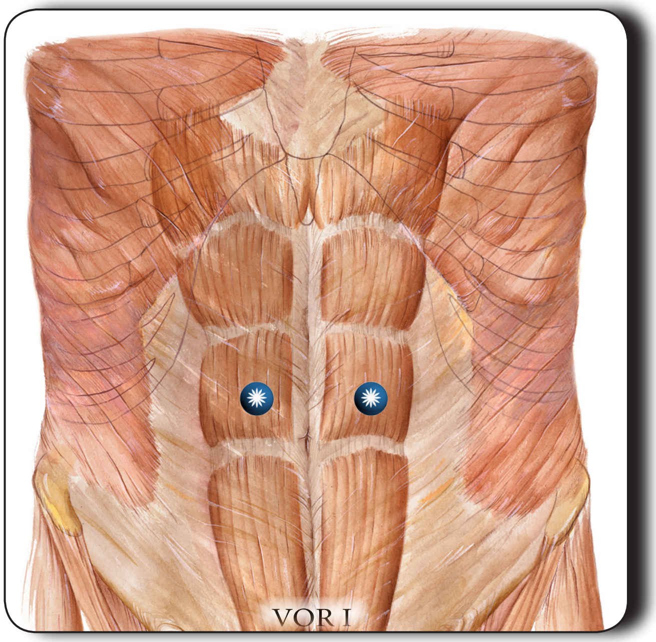
NUTRIENT SOURCE: Chlorophyll
1. Core Prostate (NW)
2. Core Health Reserve (NW)
3. B12 Lozenge NW)
4. Chlorophyll Plus (NW)
5. Chloroplex (NW)

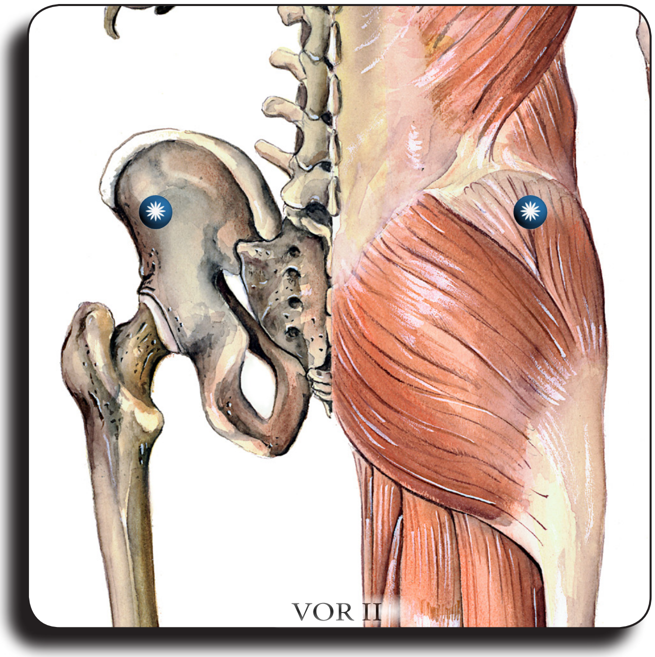


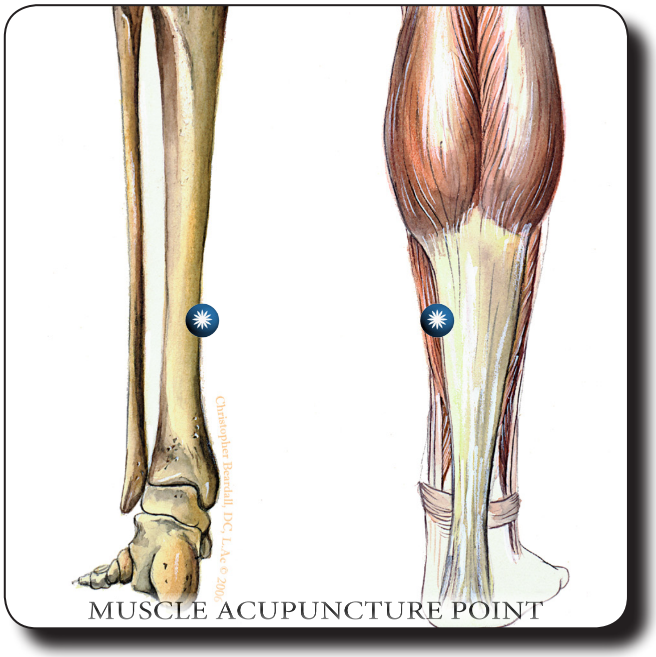

SEMISPINALIS CAPITIS


NEUROVASCULAR


NEUROLYMPHATIC


VOR I


VOR II


Christopher Beardall, DC, L.Ac © 2006
MUSCLE ACUPUNCTURE POINT

Muscle 332: SEMISPINALIS CAPITIS

ORIGIN: Tip of transverse process of T6 and T7 and articular process of C4-C7.

INSERTION: Between the inferior and superior nuchal lines of the occiput.

ACTION: Extends the head and rotates it toward the same side.

TEST:

Patient: Prone. Rotate head 10-20° , Flex head on neck, extend neck on trunk 20°.

Doctor: Flex neck on trunk.

NEUROVASCULAR: (Ant/Midline) Frontal bone at hair line.

NEUROLYMPHATIC: (Post/R) 3rd ICS, halfway between spine and scapula.

VISCERAL ORGAN:

I. Spleen: (Ant/BL) 1 1/2" superior and 2" lateral to umbilicus.

II. Penis/Vaginal Vault: (Post/BL) Gluteus medius belly 1-2" inferior to crest, level of L5

M. A. P. : K8.7

V.L. : T4R

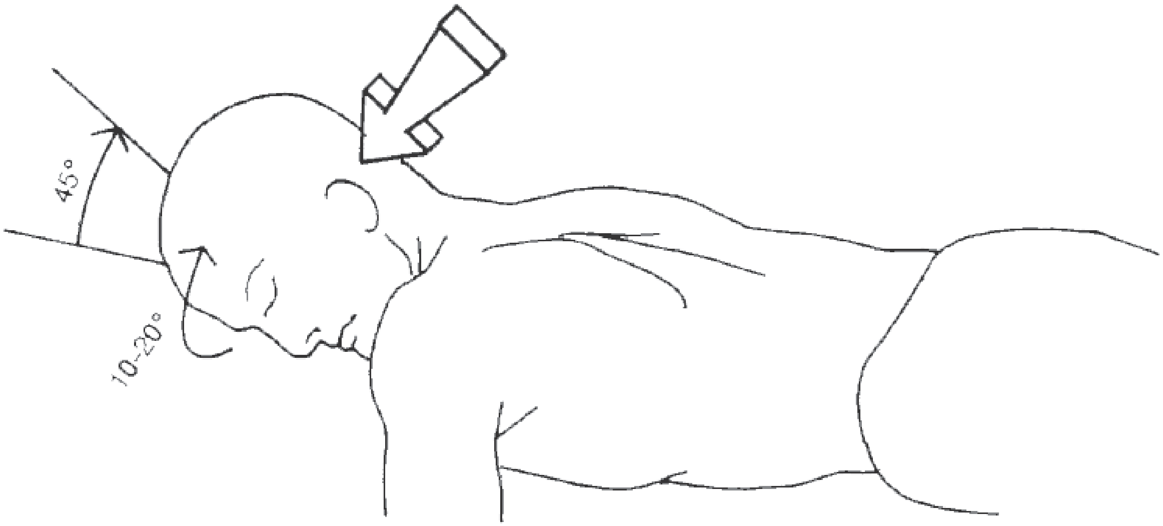
L. B. V.L. : T7R

M. M. : C3

CRANIAL: In Research

FOOT: In Research

NUTRIENT SOURCE: Potassium
1. Core Potassium



CHAPTER V:

CRANIAL MANIPULATION

GENERAL RULES FOR CRANIAL CORRECTION

1. Most Cranial bones are therapy localized anywhere on their external surface.

2. Some Cranial bones are located under the external surface of the cranium and must be therapy localized indirectly, these bones reflex their mechanical stress to specific areas of other bones. They are as follows:

A. Ethmoid - Frontal bone
B. Inferior Concha - Maxillary bone
C. Palatine - Maxillary bone
D. Vomer - Maxillary bone
E. Lacrimal - Maxillary bone

3. Cranial correction is performed in the direction which negates the positive therapy localization.

4. Most Cranial bones are aided in correction by appropriate muscle pull. Using the section on TMJ muscle challenge, find the TMJ muscle action which two-points to the Cranial TL.

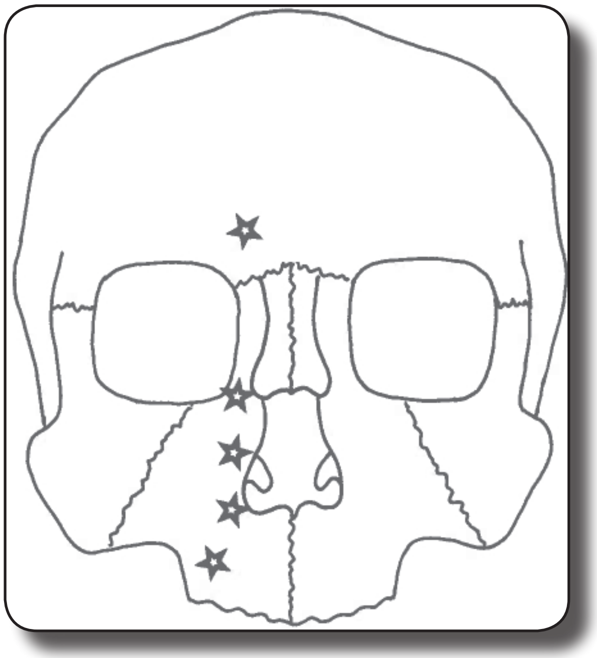
5. In the correction activate the TMJ muscles and apply pressure on the appropriate Cranial bone through both phases of respiration.

6. Repeat the above until the bone is moving during all phases of respiration.

7. Challenge the Cranial bone with the tapping technic.

8. Continue correction, if necessary, until the positive therapy localization has been negated.

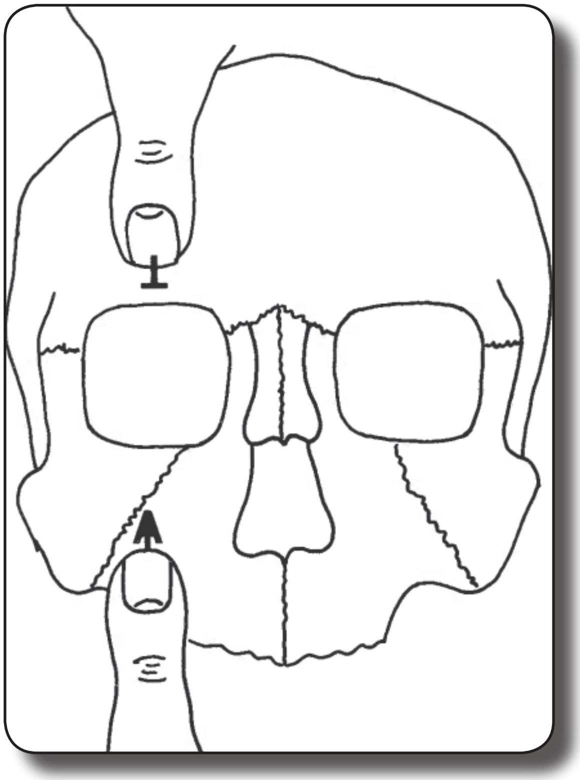
Note: Cranial diagnostic procedure and treatment has evolved since the original discoveries of Dr. Sutherland. The following have made significant contributions to the cranial procedures located in this book: Dr. George Goodheart, Dr. Richard Schroeder, Dr. William Heath, Dr. Van Rumpt and Dr. Alan Beardall.



A-P Therapy Localization

Superior - Inferior

1. Ethmoid
2. Lacrimal
3. Vomer
4. Inferior Conchae
5. Palatine



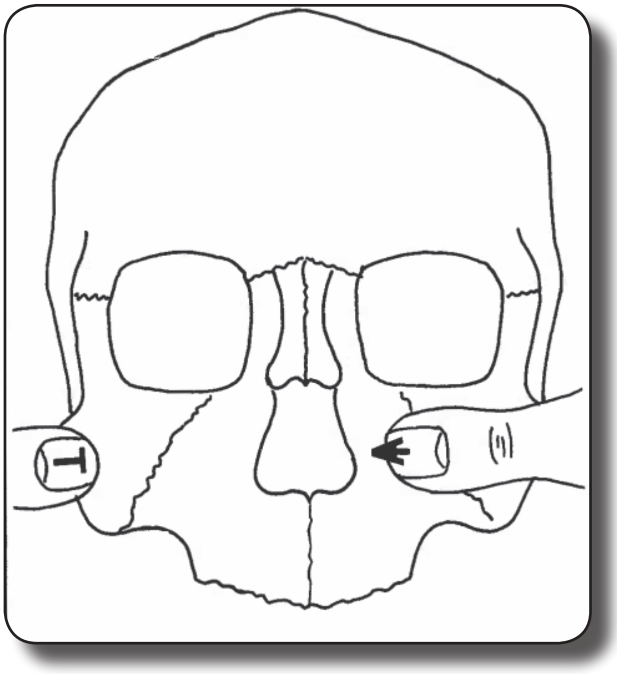
Maxillary, A-P

MAXILLARY, A-P

TL: On any part of the maxillary bone, there are basically two types of corrections. The line of drive determines the diagnosis.

Correction:

1. The plane of fixation is inferior to superior or superior to inferior. The latter is the more common.
2. Correctional force is applied by the thumb according to the diagnosis. Counter pressure is applied at the frontal bone.
3. Follow general rules for cranial correction.



Maxillary, Med. - Lat.

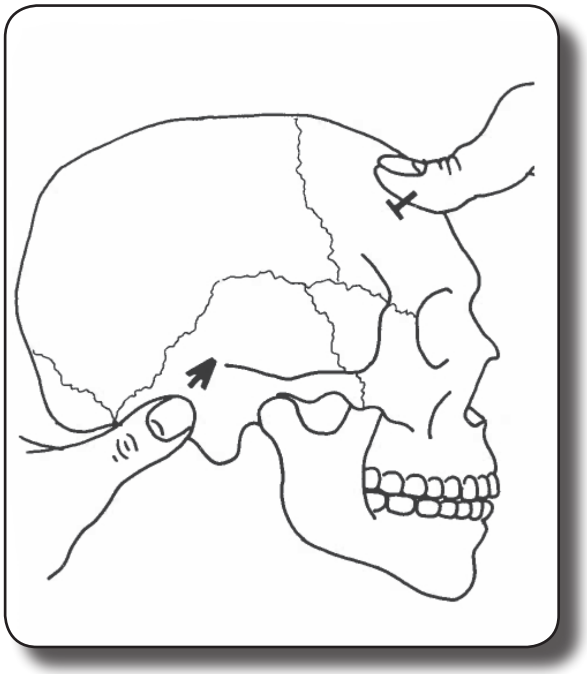
MAXILLARY, MED - LAT.

TL: On any part of the maxillary bone.

Correction:

1. The plane of fixation is medial to lateral or away from midline.
2. Correctional force is applied by the thumb according to the diagnosis. Counter pressure is applied on the opposite zygomatic bone with the opposite thumb. Fingers are used to stabilize the head.
3. Follow general rules for cranial correction.

Temporal, External



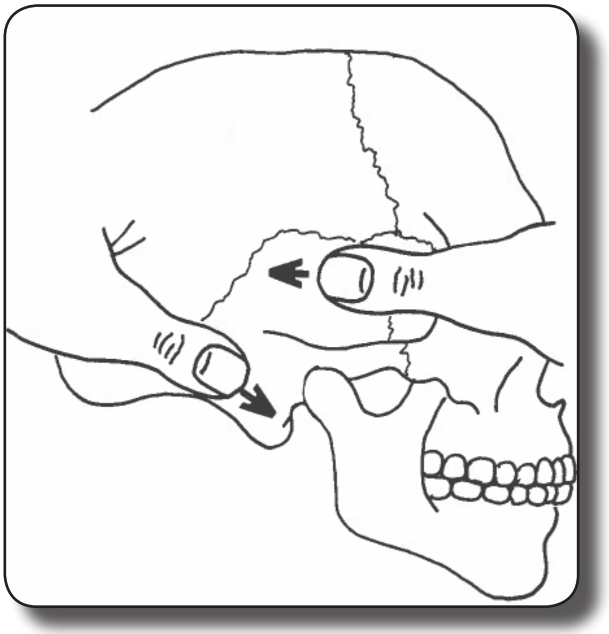
Temporal, External

TL: On any part of the temporal bone. Correctional force determines the diagnosis.

Correction:

1. The plane of fixation is an extension fault or anterior to posterior fixation.
2. Correctional force is applied by the thumbs in an anterior or clockwise rotation. Counter pressure is applied by the fingers on the occiput and the frontal bone.
3 The temporal bone is occasionally locked in a superior to inferior or inferior to superior plane. This is a rocking motion. Correctional force determines the diagnosis.
4. Follow general rules for cranial correction.

Temporal, Internal

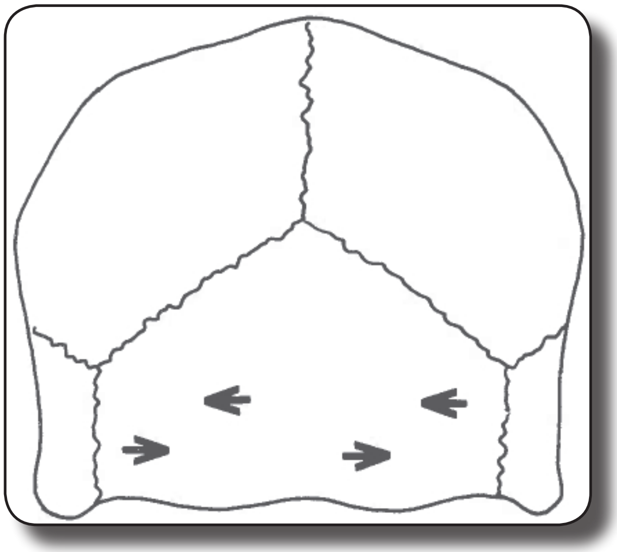


Temporal, Internal

TL: On any part of the temporal bone. Correctional force determines diagnosis.

Correction:

1 The plane of subluxation is a flexion fault or a posterior to anterior fixation. Correctional force is applied by the thumbs in a posterior or counter-clockwise rotation.
2. Counter pressure by the fingers is on the opposite side of the head and the occiput.
3. The temporal bone occasionally is locked in a superior to inferior or inferior to superior plane. This is a rocking motion. Correctional force determines the diagnosis.
4 Follow general rules for cranial correction.



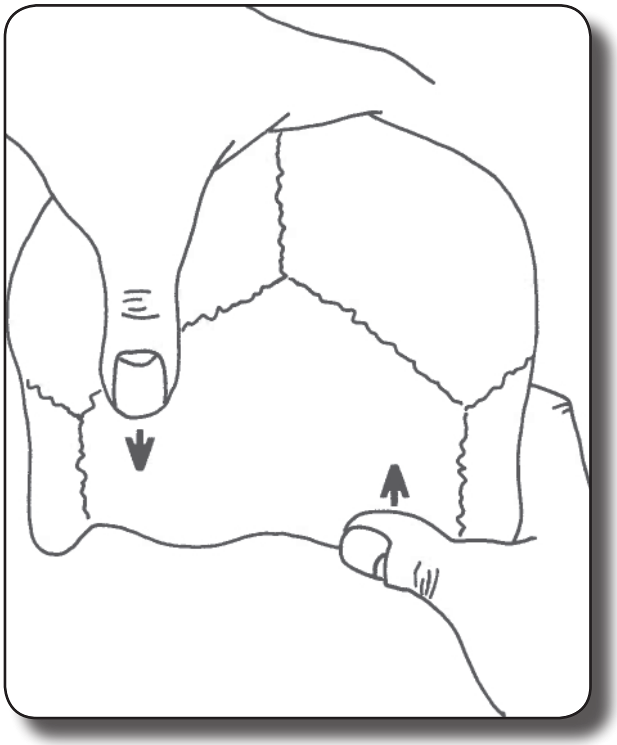
Occiput, Lateral

Occiput, Lateral

TL: Any part of the Occiput. The lateral Occiput is differentiated by direct lateral correction negating a positive TL.

Correction:

1. Lateral occiputs are adjusted from L-R or R-L.
2. Counter pressure is used to support the neck.
3. Follow general rules for cranial correction.



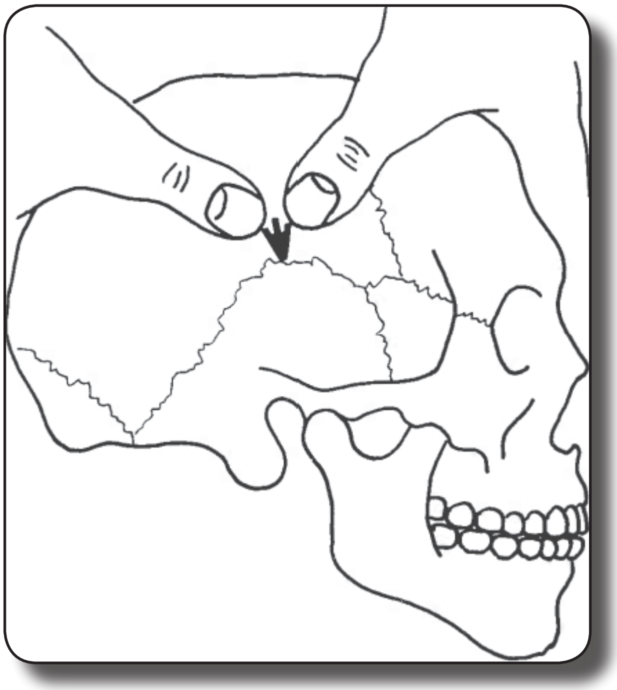
Occiput, Universal

Occiput, Universal

TL Area: On any part of the occiput. The universal occiput is differentiated by the direction of the correction.

Correction:

1. Universal subluxation is a rotatory movement of the occiput. Challenge for direction.
2. Counter pressure is applied to continue the correction.
3. Follow general rules for cranial correction.



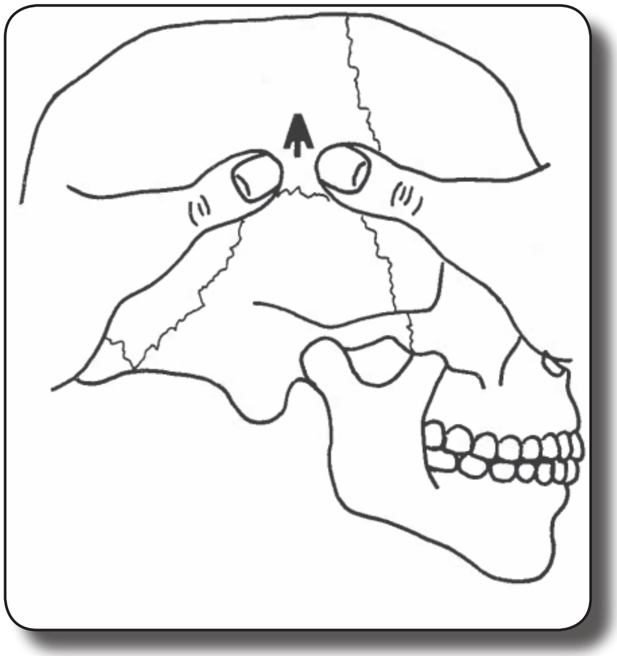
Parietal, Bulge

PARIETAL, BULGE

TL: On any part of the parietal bone. Correctional force determines the diagnosis.

Corrections:

1. This plane of subluxation is always a superior movement of this bone. Pressure is exerted bilaterally with the thumb.
2. Counter pressure is applied on the opposite side of the head with the fingers.
3. Follow general rules for cranial correction.



Parietal, Descent

PARIETAL, DESCENT

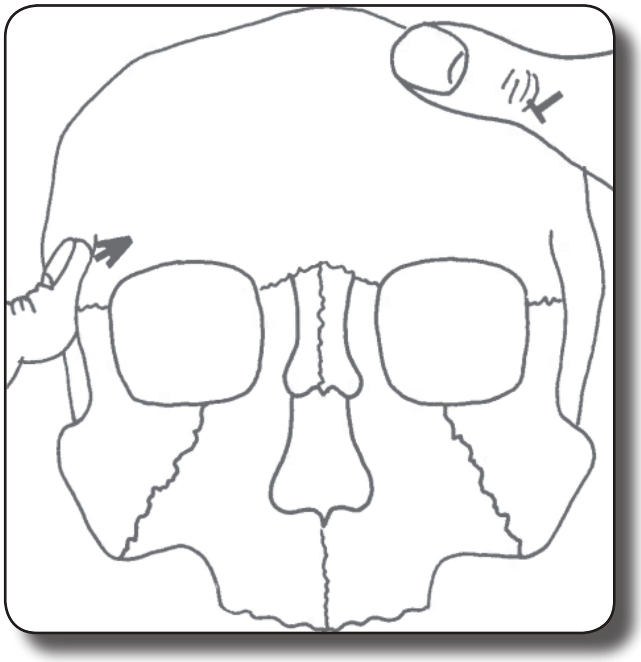
TL: On any part of the parietal bone.

Correction:

1. This plane of subluxation is always inferior. Corrective pressure is exerted with the thumbs in a superior direction while counter pressure is applied on the opposite side of the head.

   Note: Occasionally the parietal bone is fixated in an anterior or posterior plane. Following diagnosis, simply correct the bone in a direction which negates the positive TL.

2. Follow general rules for cranial correction.



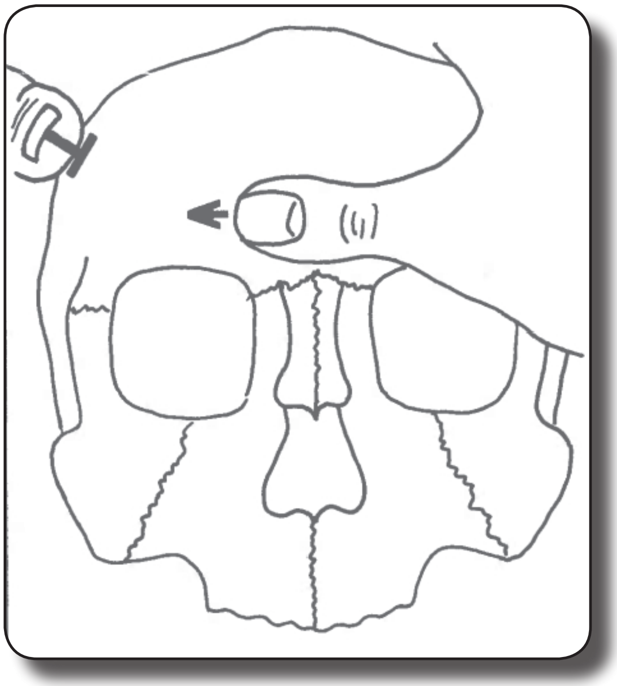
Frontal, External

Frontal, External

TL: On any part of the frontal bone except in the area where the ethmoid is diagnosed. Generally the frontal eminence is used. Corrective force determines diagnosis.

Correction:

1. The plane of subluxation is away from midline. Usually pain is felt at the sphenoid-frontal suture. Corrective force is applied by the thumbs toward midline.
2. Counter pressure is applied on the opposite side of the head by the fingers.
3. Follow general rules for cranial correction.



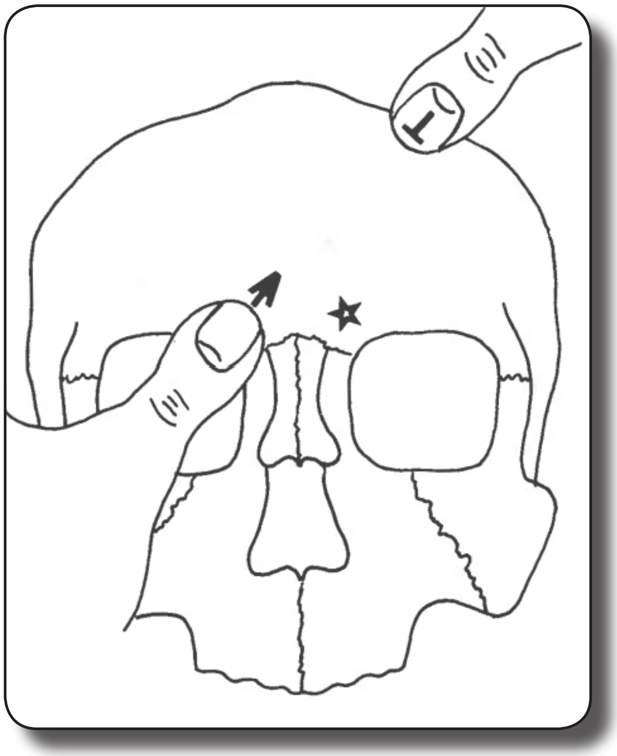
Frontal, Internal

Frontal, Internal

TL: On any part of the frontal bone except in the area where the Ethmoid is diagnosed. Generally the frontal eminence is used. Corrective force determines diagnosis.

Correction:

1. The plane of subluxation is movement of the bone towards the midline. Corrective force is applied by the thumb from midline outward.
2. Counter pressure is applied generally at the occiput and parietal area.
3. Follow general rules for cranial correction.



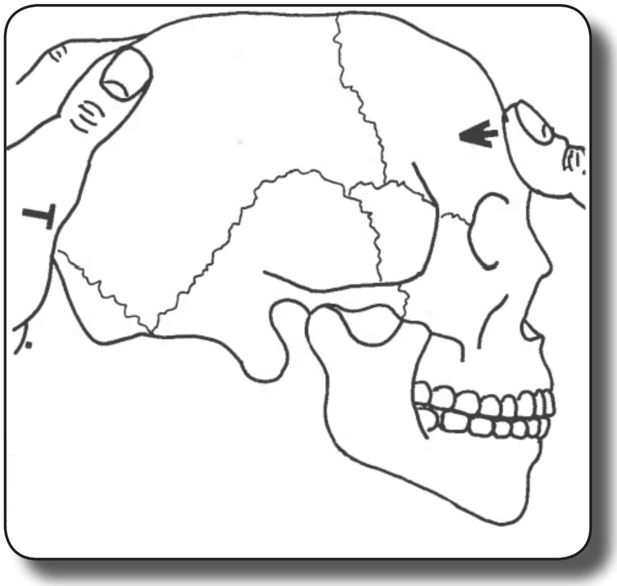
Ethmoid

Ethmoid

TL: On the frontal bone 1” superior to the glabella 1/2” lateral to midline and just superior to the supraciliary arch.

Correction:

1. The corrective hand or thumb is place over the TL area.
2 Counter pressure is placed on the opposite side of the head.
3. Follow general rules for cranial correction



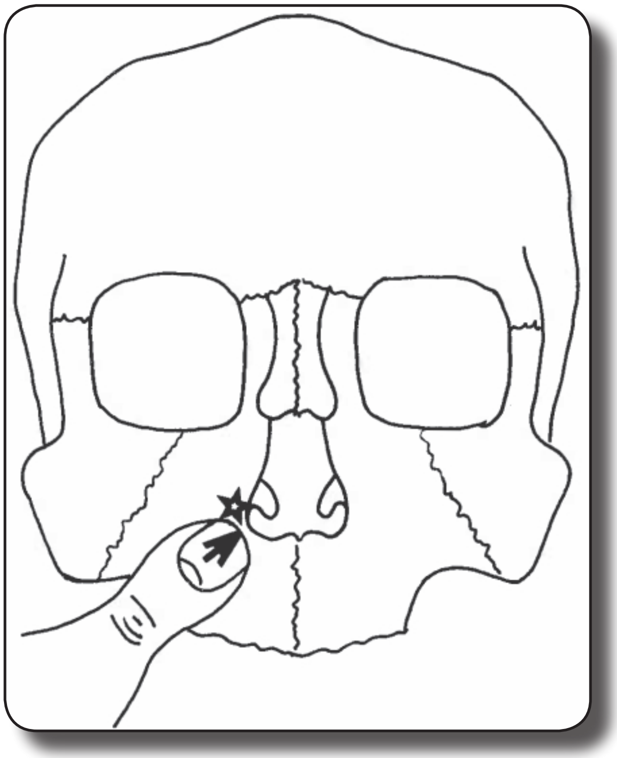
Glabella

Glabella

TL: The glabella portion of the frontal bone 1” superior to the nose.

Correction:

1. The plane of fixation of the glabella is a sphenoid-occipital flexion or extension fault.
2. Correctional force is applied by the thumb to the glabella in an anterior to posterior sagittal plane Counter pressure is applied by the palm of the opposite hand on the occiput.
3. Follow general rules for cranial correction.



Inferior Conchae

Inferior Conchae

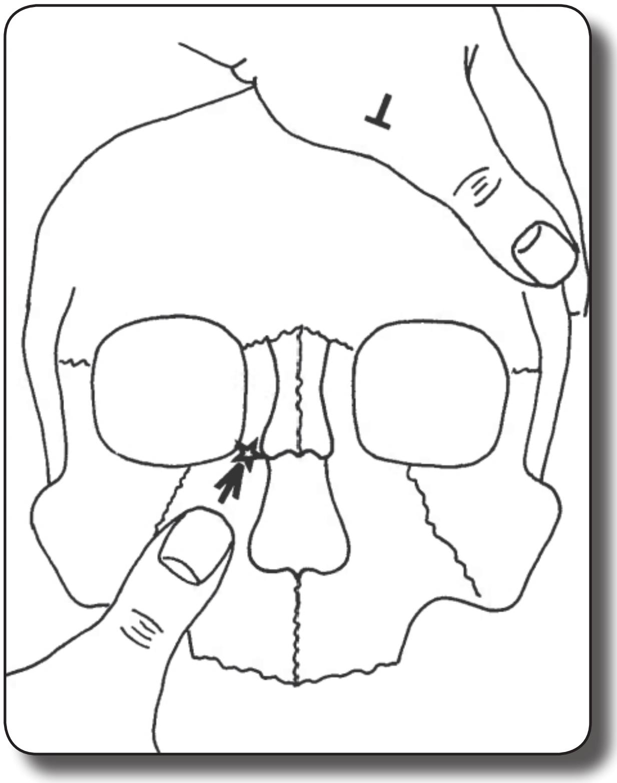
TL: Located on the maxillary bone just lateral to the end of the nose.

Correction:

1 The most common plane of subluxation is medial to lateral.

2. Counter pressure is applied on the opposite side of the head at the lateral-frontal area.

3. Follow general rules for cranial correction.



Lacrimal

Lacrimal

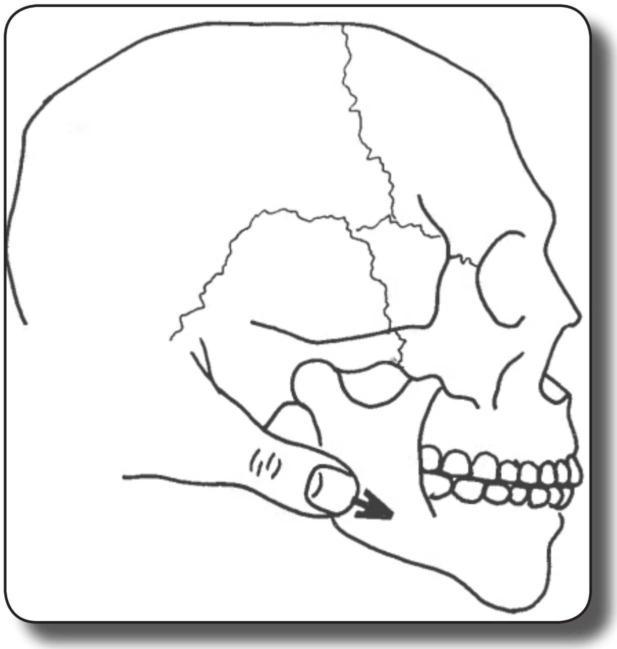
TL: Just lateral to the most inferior portion of the nasal bone on the maxillae.

Correction:

1. The usual plane of fixation is inferior.

2. Correctional force is applied superiorly on the maxillary bone at its area of TL. Counter pressure is applied at vertex of head.

3. Follow general rules for cranial correction.



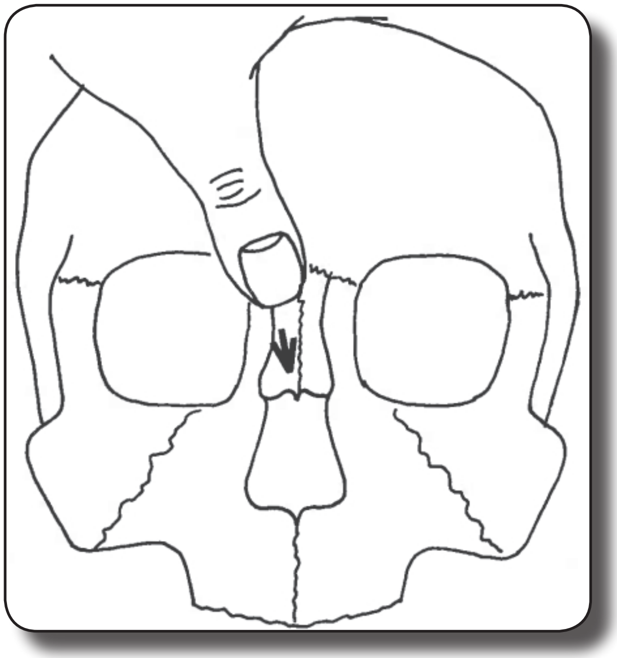
Mandible

Mandible

TL: Condyle of Mandible

Correction:

1. The subluxation or fixation of the mandible may occur in any plane. The most frequent plane is a unilateral posterior subluxation.
2. Correctional force is applied by the thumb contact on the posterior superior aspect of the ramus of the mandible
3. Follow general rules for cranial correction.



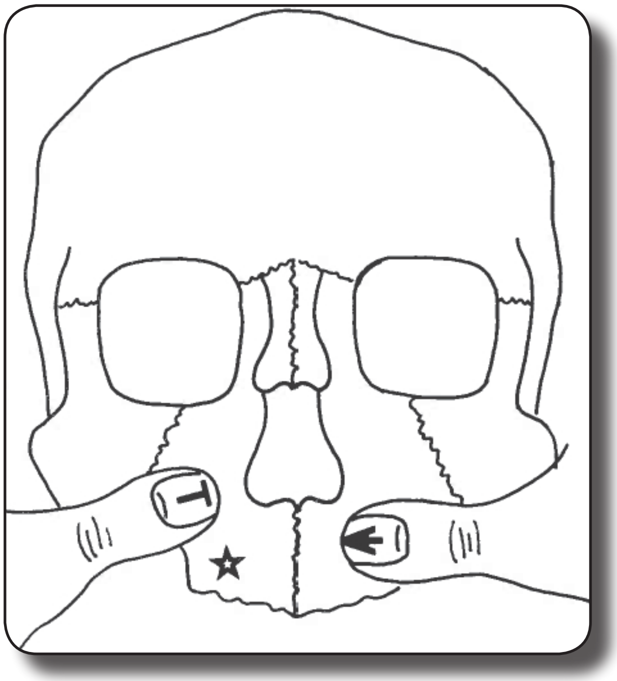
Nasal

Nasal

TL: Nasal Bone

Correction:

1 The plane of fixation is usually superior.
2. Correctional force is applied by the thumb in a superior to inferior direction or according to appropriate diagnostic information.
3 Follow general rules for cranial correction.



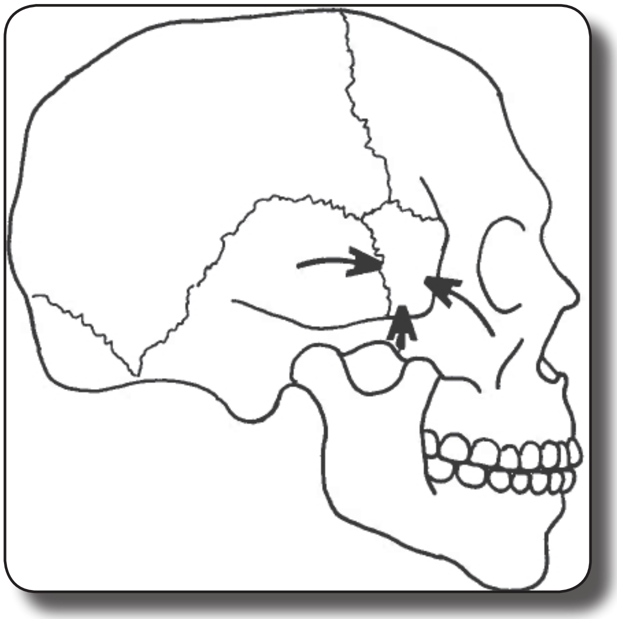
Palatine

Palatine

TL Area: On the maxillary bone 1/2" superior to the 1st molar.

Correction:

1. The most common plane of subluxation is from medial to lateral.
2. Counter pressure is placed on the opposite maxillary bone.
3. Follow general rules for cranial correction.



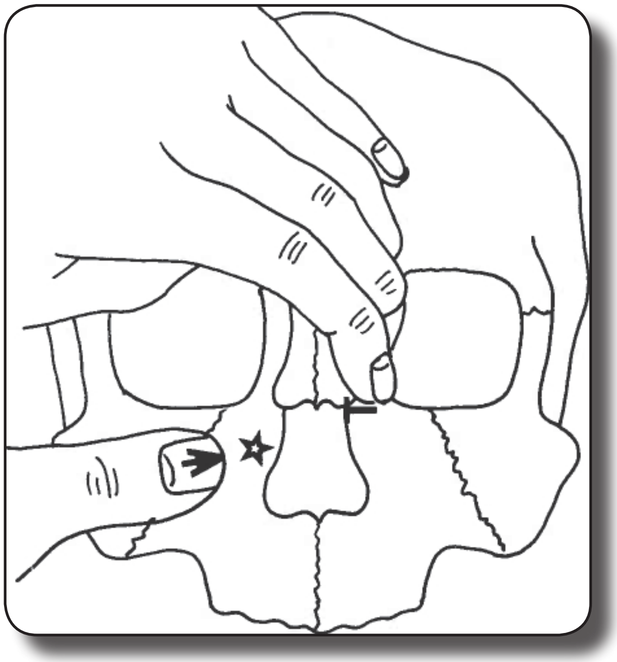
Sphenoid

Sphenoid

TL: Anywhere on the external surface of the sphenoid.

Correction:

1. The sphenoid can be fixated or subluxated in almost any plane of motion. The most common planes are flexion, extension, superior to inferior and sometimes lateral.
2. Counter pressure in the sphenoid correction is often applied in the same direction on the opposite side, especially if the correction is a flexion or extension fault.
3, Follow general rules for cranial correction.



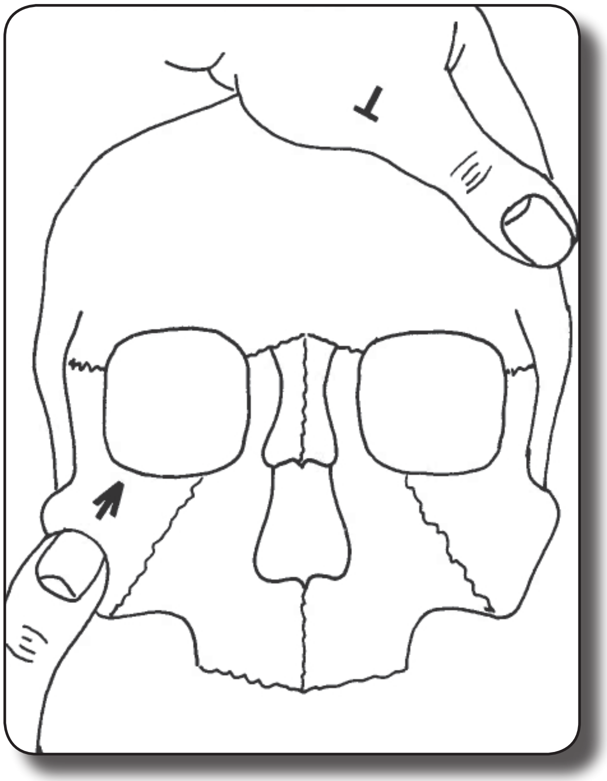
Vomer

Vomer

TL Area: On the maxillary bone just lateral to the middle of the nose.

Correction:

1. The most common plane of subluxation is medial to lateral.
2 Correctional force takes place through the thumb via the zygomatic and maxillary bones. Counter pressure is applied with the fingers contacting the opposite side of the nose.
3. Follow general rules for cranial correction.



Zygoma

Zygoma

TL: Zygomatic Bone

Correction:

1. The usual plane of subluxation is lateral and inferior.
2. Correctional force is applied with the thumb in a superior and medial direction. Counter pressure is applied with the opposite palm of the hand on the opposite frontal bone.
3. Follow general rules for cranial correction.

CHAPTER VI:

REFERENCES

ORGANS

Adrenal
114 Masseter - Superficial Division
302 Sternohyoid

Bladder
290 Digastric - Anterior Belly
296 Mylohyoid

Colon
270 Upper Trapezius - Scapular Division

Duodenum
286 Platysma - Anterior Division

Ductens Deferens
278 Scalenus Anterior

Eye
270 Upper Trapezius - Scapular Division
298 Geniohyoid
306 0mohyoid

Gallbladder
274 Sternocleidomastoid - Sternal Division
282 Scalenus Medius

Gallbladder - Arteries
098 Orbicularis Oris - Upper Division
292 Digastric - Posterior Belly

Gonads
100 Orbicularis Oris - Upper Division
102 Buccinator

Hepatic Duct
300 Sternohyoid

- Internal Ear
  - 272 Upper Trapezius - Clavicular Division

- Kidney
  - 284 Scalenus Posterior
  - 302 Sternothyroid

- Liver
  - 098 Orbicularis Oris - Upper Division

- Lungs/bronchioles
  - 114 Masseter - Superficial Division

- Nose
  - 304 Thyrohyoid

- Pancreas
  - 274 Sternocleidomastoid - Sternal Division
  - 288 Platysma - Posterior Division

- Pancreas - Sugar
  - 110 Temporalis - Parietal Division
  - 286 Platysma - Anterior Division

- Pancreatic Duct System
  - 112 Temporalis - Occipital Division
  - 290 Digastric - Anterior Belly

- Parathyroid
  - 126 Pterygoid Externus Lateralis - Lower Division

- Penis/Vaginal Vault
  - 332 Semispinalis Capitus

- Pharynx
  - 110 Temporalis - Parietal Division

Pineal

112 Temporalis - Occipital Division
124 Pterygoid Externus Lateralis - Sphenoid Division

Pituitary, Anterior

100 Orbicularis Oris - Inferior Division
314 Longus Capitus

Pituitary, Posterior

118 Masseter - Deep Division
120 Pterygoid Internus Medialis - Sphenoid Division

Prostate/Uterus

300 Sternohyoid
314 Longus Capitus

Rectum

288 Platysma - Posterior Division

Spleen

306 0mohyoid
332 Semispinalis Capitus

Stomach -veins

292 Digastric - Posterior Belly

Submandibular Lymphatics of Face and Neck

276 Sternocleidomastoid - Clavicular Division
282 Scalenus Medius

Testicles/Ovaries

124 Pterygoid Externus Lateralis - Sphenoid Division
126 Pterygoid Externus Lateralis - Lower Division

Thymus

122 Pterygoid Internus Medialis - Palatine Division
272 Upper Trapezius - Clavicular Division
304 Thyrohyoid

Thyroid
    118 Masseter - Deep Division
    120 Pterygoid Internus Medialis - Sphenoid Division
    292 Stylohyoid
    298 Geniohyoid

Tonsils
    122 Pterygoid Internus Medialis - Palatine Division
    296 Mylohyoid

Transverse Colon
    102 Buccinator

Ureter
    294 Stylohyoid

Urethra
    284 Scalenus Posterior

VERTEBRAL LEVELS

Cervical Vertebral Levels

	LEFT	RIGHT
C1		
C2		
C3	122, 290	098
C4		
C5		
C6		
C7		

Thoracic Vertebral Levels

T1	100	286
T2		300
T3	302	
T4		332
T5	110	
T6	314	276
T7		
T8		274
T9	102	298
T10	272	
T11		288
T12	284	296

Lumbar Vertebral Levels

Ll	126	278
L2	270	
L3	304	112, 114, 306
L4	118, 282	124, 292
L5		120, 294

CRANIAL

ETHMOID	284, 292
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OCCIPUT	270
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Foot

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NAVICULAR	102, 296
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3RD CUNIEFORM	100, 286, 302, 304
1ST METATARSAL	126
2ND METATARSAL	112, 118
3RD METATARSAL	272
4TH METATARSAL	276, 286, 290
PROXIMAL PHALANX - GREAT TOE	114
PROXIMAL PHALANX - 2ND TOE	120, 298
DISTAL PHALANX - 2ND TOE	288

GLOSSARY of ABBREVIATIONS

Ant	Anterior
ASIS	Anterior superior iliac spine of ilium
BL	Bilateral
Contralateral	Pertains to opposite side of the body (R or L) from reference
CN	Cranial Nerve
EAC	External Auditory Canal
EOP	External occipital protuberance
I.C.S.	Intercostal space
Ipsilateral	Pertains to same side of the body (R or L) as reference
L	Left or Lumbar
Lat	Lateral
L.B.	Lovett Brother
M.A.P.	Muscle acupuncture point
Midline	Midline of the body or organ
M.M.	Myomere, direct nerve supply to muscle
M.T.P.	Muscle Testing position
Post	Posterior
PSIS	Posterior superior iliac spine of ilium
Sup	Superior
R	Right
SCM	Sternocleidomastoideous muscle
V.L.	Vertebral Level, A level of the spinal column where the somato-visceral relationships are expressed
VOR	Visceral Organ Reflexes

MERIDIANS

B	Bladder
Cv	Conception Vessel
Cx	Circulation / Sex
G	Gallbladder
H	Heart
K	Kidney
Li	Large Intestine
Lu	Lung
Lv	Liver
P	Pericardium (same as Circulation Meridian)
Si	Small Intestine
Sp	Spleen
St	Stomach
Tw	Triple Warmer
X	Extra (outside of normal Meridians)
Gv	Governing Vessel

NUTRIENT SOURCE

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P.O. Box 950
Douglas, Wyoming 82633
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